

# Supporting Caring Efficacy in Nurses through Standardization of Communication

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## Abstract

**Background:** Patient satisfaction scores are one of the measurements of performance and quality of care. Hospitals are facing up to two percent reward or penalty of their total Medicare reimbursement based on the results of clinical processes and patient experience measures.

**Local Problem:** The staff addressed the lack of standardized care experience behaviors to facilitate and enhance nurse communication.

**Methods:** Lewin's change theory is the theoretical framework used for this project.

**Intervention:** Behavior standards were developed and implemented on a 50-bed medical-surgical unit from August 25 to November 25, 2020, to support caring efficacy in nurses through standardization of communication.

**Results:** Forty-eight nurses participated in this quality improvement project. A statistically significant difference was found between the pre-and post-Caring Efficacy Scale (CES) scores after the implementation of the behavior standard  $sp < .0001$  ( $p = 3.8475E-10$ ).

**Conclusion:** The use of standardized behavior standards was an effective intervention to improve the nursing communication process. The intervention can be easily replicated and sustained in a strategic care experience program, while ensuring better patient outcomes and strategically improving nurse and patient satisfaction.

**Key Words:** Behavior Standards; HCAHPS Scores; Nursing Communication; Patient Satisfaction

**Abbreviations:** Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), National Research Corporation (NRC), Patient Protection and Affordable Care Act (PPACA), Quality Improvement (QI), and Southern California (SCAL). Supporting Caring Efficacy in Nurses through Standardization of Communication

The overhaul of the healthcare system that is required to improve the quality of care, reduce spiraling healthcare costs, and make healthcare accessible to all stakeholders necessitates ongoing changes in healthcare organizations. The challenge for a community hospital in Southern California (SCAL) was to improve quality and care experience delivery through an ongoing process of innovation, restructuring of systems and processes, and implementation of aligned care experience behaviors to increase patient satisfaction and augment clinical outcomes. Patient satisfaction scores serve as process and system indicators for financial

reimbursement from government and private insurance agencies and as an impetus for the medical center to guide system change.

The leadership of the community hospital in SCAL adopted an exclusive focus on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores to measure performance and patient outcomes; evaluate the degree of quality improvement; and analyze service in terms of standards, criteria, and patient-centered indicators. To improve patient satisfaction scores, the medical center made a number of changes specific to the nursing communication domain to achieve expected outcomes and operationally adopted different models of care to enhance patient care delivery. A key starting point for care experience improvement is a commitment by healthcare leaders to enhance the effectiveness of communication among nurses (Riebling et al., 2019).

## Problem Description

The Patient Protection and Affordable Care Act (PPACA) of 2010 provided valuable lessons in how political forces shape health policy, particularly in nursing practice. The landmark health reform law created an incentive system that rewarded hospital organizations for the quality of care and high levels of patient satisfaction among Medicare beneficiaries (Carter & Silverman, 2016). Consequently, hospitals were challenged to restructure, innovate, and change in order to remain fiscally viable in the face of a shifting reimbursement system through the Centers for Medicare and Medicaid Services (CMS) value-based purchasing (VBP) program (Owens et al., 2017). CMS incentivized hospitals to improve the patient experience by directly tying reimbursement to the result of patient surveys (Bumpers et al., 2019). Patient satisfaction scores derived from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey consist of ten composites e.g. nurse communication. Each composite has assigned weights (percentages) used to score each domain, thus formulate the reimbursement star measure equation (Owens et al., 2017). The star ratings were developed by CMS to make it easier for consumers to understand the publicly reported information.

In the community hospital, there was a gap in communication interventions for nurses. The first three questions in the HCAHPS survey outlines nurses' ability to communicate with respect and courtesy, listen attentively, and explaining things clearly (National Research Corporation [NRC], 2019). The medical center scored below the 75<sup>th</sup> percentile in all three nursing communication composite elements from January 2018 to December 2019 (NRC, 2019). The organizational scores in this domain for the first two quarters of 2019 were 68 and 70<sup>th</sup> percentile respectively (NRC, 2019).

Communication with nurses is a critical element of hospital quality, safety, and care experience. Nurses have the most interaction with patients and are positioned to have the greatest impact on the overall care experience journey (Lotfi et al., 2019). Nursing communication is foundational. Strong correlations with other HCAHPS composites indicated a likelihood that focusing on nursing communication will improve performance across several other HCAHPS star measures (Carter & Silverman, 2016). By focusing quality improvement (QI) efforts on key nursing communication engagement factors, hospital organizations could potentially affect 25% of their total VBP incentive (Center for Medicare and Medicaid Services, 2018) (Table 1). Hospital organizations are experiencing significant variability in nurse communication scores (Allenbaugh et al., 2019). National data showed hospitals lagging behind the 75<sup>th</sup> percentile benchmark (CMS, 2018).

**Table 1:** Hospital VBP Domains and Relative Weights for Fiscal Year (FY) 2018 and Subsequent Years

Domain	Percentage
Safety	25%
Clinical Care	25%
Efficiency and Cost Reduction	25%
Patient and Caregiver-Centered Experience	25%

Note: These value-based practice percentages still applies for the year 2020.

After completing the literature search on PubMed and CINAHL, 31 articles were selected. The articles were selected based on their strengths and limitations, relevance to the topic, and methodological quality of the study's design using the Polit and Beck level of evidence scale (Polit & Beck, 2018). The themes that supported the sustainability and spread of a formidable nursing communication process that emerged from the literature included the use of evidence-based interventions such as behavior standards, rounding, bedside shift reports, and discharge protocols.

## Nursing Communications: Importance and Issues

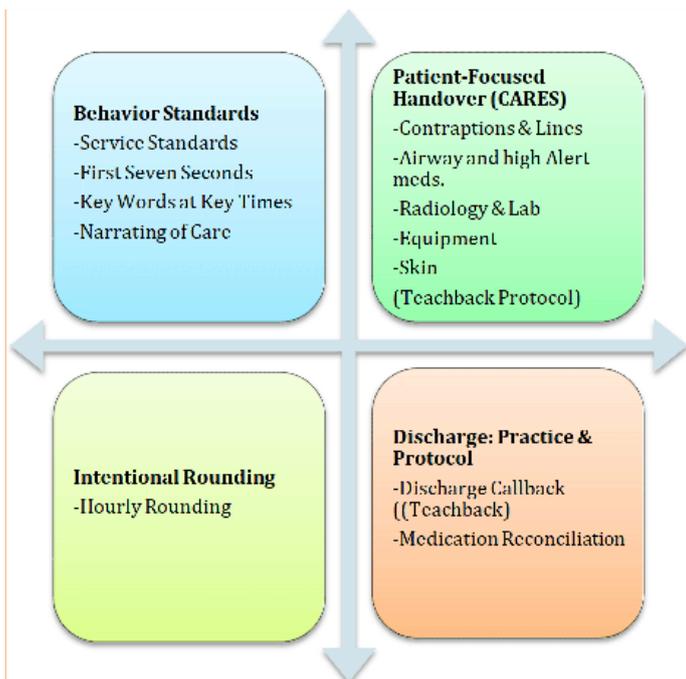
A starting point for care experience improvement was a commitment to increase nursing communication composite scores, one of the nine domains of the HCAHPS survey. The first three questions in the HCAHPS survey outline the nurse's ability to communicate with respect and courtesy, listen attentively, and explain things clearly. The evidence-based issues surrounding nursing communication have revolved around the following: structure, standards, support, spread, and sustainability (Herman et al., 2019). Structure means no fragmenting of the evidence-based interventions. The implementation of the interventions should be systematic, organized, patient-centered, and establish a flow with less variability along the care experience journey (Lin et al., 2015). The standard of execution should be consistent and have a strong association between the elemental components of nursing communication (Stimpfel et al., 2016). All stakeholders should support the initiative by taking ownership from the inception of the program until positive outcomes are achieved (Daniels, 2016). The spread should correspond with the capacity of the evidence-based interventions to be generalizable in any setting or location, practice, and population (Bansal et al., 2016). Sustainability means delivering great results at a certain rate or level in the context of reliability and transformation (Manss, 2017).

## Nursing Communication: Bundle Elements

Meaningful nurse-patient communication is pivotal to building trust, alleviating uncertainty, developing mutual relationships, and creating a purposeful connection to enhance the current situation surrounding the care journey (Bumpers et al., 2019). Nursing communication is a linchpin to high reliable systems and processes, patient satisfaction and safety, and an engaged, high-performing workforce (Allenbaugh et al., 2019). Hospital organizations have focused on different strategies to improve the scores. Some initially implemented training focused on communication whereas others have focused on building a culture and reputation (Stimpfel et al., 2016). Although there are worthwhile strategies, the CMS objectified that nursing communication has the strongest correlation with most of the HCAHPS domains particularly with the overall rate of hospital care as evidence by the synthesis of 3.1million HCAHPS surveys in its 2014 HCAHPS Patient-Level Correlations (Briggs et al., 2018).

The Institute of Healthcare Improvement (IHI) developed the concepts of bundles to assist in reliably delivering the best evidence to care for patients (Riebling et al., 2019). A bundle is a straightforward set of single evidence-based practice interventions links together into a package of associated tactical elements. It is designed to make the process more reliable for care providers to apply. The standard bundle elements, when executed collectively and reliably, have been

proven to improve patient satisfaction scores (Riebling et al., 2019). The standardized nursing communication bundles include behavior standards (Huron Consulting Group Incorporation, 2019; La Chapelle, 2018), patient-focused handover (Shimp & Sims, 2016), intentional rounding (Bansal et al., 2016), and discharge practice (Chan et al., 2015).



**Figure 1.0:** Standardized Nursing Communication Bundle

### Behavior Standards

Behavior standards allow providers of care to learn the structure and accountability that are necessary to foster a trusting relationship (La Chapelle, 2018). Scripting, using key words at key time's technique, and communication skills training has been advocated to be the solution in promoting behavior standards necessary to increase nursing communication scores. Studer Group promoted using key words at key times with key behaviors strategy to guide healthcare staff in a positive direction (Huron Consulting Group Incorporation, 2019). Relatedly, StuderGroup emphasized finding the right words at the right time builds a culture of operational excellence in care experience (Huron Consulting Group Incorporation, 2019). While keywords are important, these communication behaviors are not a script. The keywords framed a simple, consistent way to integrate fundamental patient communication elements into every patient encounter (La Chapelle, 2018). The elements of the behavior standards include service standards, first seven seconds, key words at key times, and narrating of care.

### Project Goal and Specific Aims

The goal of this quality improvement project was to support caring efficacy in nurses' through standardization of communication on a 50-bed medical-surgical unit at a medium-size community hospital in SCAL over a three-month period. The specific aims are:

1. Assess the current state of nursing communication practices in the unit.

2. Develop concrete and standardized behaviors standards as a strategy to enhance the communication skills of the nurses.
3. Create a playbook/toolkit for the nursing communication initiative, which will serve as a practice guide of the organization's commitment to care experience.
4. Implement the behavior standard elements to the nurses in the unit.
5. Create recommendations for sustainment of the behavior standard elements.

## Methods

### Context

The quality improvement project was conducted at a community hospital in SCAL on the medical-surgical (M/S) unit. This unit had an average daily census of 50 patients and an average length of stay of 3.5 days. It serves over 625 patients per month with main diagnosis covering different cardiac diseases. The setting is not a designated area for COVID 19 and Person Under Investigation (PUI) units.

A key starting point for service improvement initiatives was a commitment by senior leadership at all levels to work with staff to empower them in their work. Instilling accountability and creating an atmosphere in which employees can take ownership remained a barrier. Despite recognizing that engaging in behavior standardization leads to greater patient satisfaction, staffs in the community hospital were not consistently using the elements as identified by leadership. The key features of the environment and the most frequently observed barriers were lack of time, lack of validation and sustainability processes, manager's inability to mentor and coach staff regarding the desired behavior, and multiple priorities in quality, safety, and experience.

### Interventions

#### Phase 1: Planning Phase

On August 25-27, 2020 the nurses completed the Caring Efficacy Scale (CES) self-scoring tool (Appendix A). The project lead administered the paper-based survey to the nurses anonymously and each nurse was given three days to complete the document. The project lead entered data onto spreadsheets in Excel® software, and preliminary results were discussed a day following the completion of the tool with the chief nurse executive, director of care experience, director, and manager of the medical-surgical (M/S) unit. A two-hour RN training was established and conducted after IRB approval on August 28-29, 2020. The two-hour training consisted of a lecture and simulation. The one-hour lecture was provided by the project lead and the one-hour simulation was provided by the four (4) medical center leaders comprising of the director of care experience, director of performance improvement, director, and manager of the M/S unit as supervised by the project lead. These leaders served as human simulators (role-playing partner), observers, and validators.

A day prior to the two-hour RN training, the project lead met with these leaders and educated them about the process. The project lead trained, simulated, observed, and validated the leaders regarding the process using the same tools that were used for the RN training. They were also oriented about their roles for the nurse training day. The nurses signed-up for one of six available training sessions to accommodate staffing flexibility. Each session only accommodated eight nurses in respect to the social distancing protocol. The training sessions were scheduled from 08:00-10:00, 10:00-12:00, and 13:00-15:00 on two consecutive days. Due to the scope and timeline set forth in the DNP curriculum, the project lead, with the approval of the site mentor only implemented Bundle 1 comprising of four (4) behavior standards.

## Phase 2: Intervention Phase (Figure 2.0)

In this phase, educational materials like posters and identification badges were used to promote standardized communication and help in facilitative coaching to improve retention.

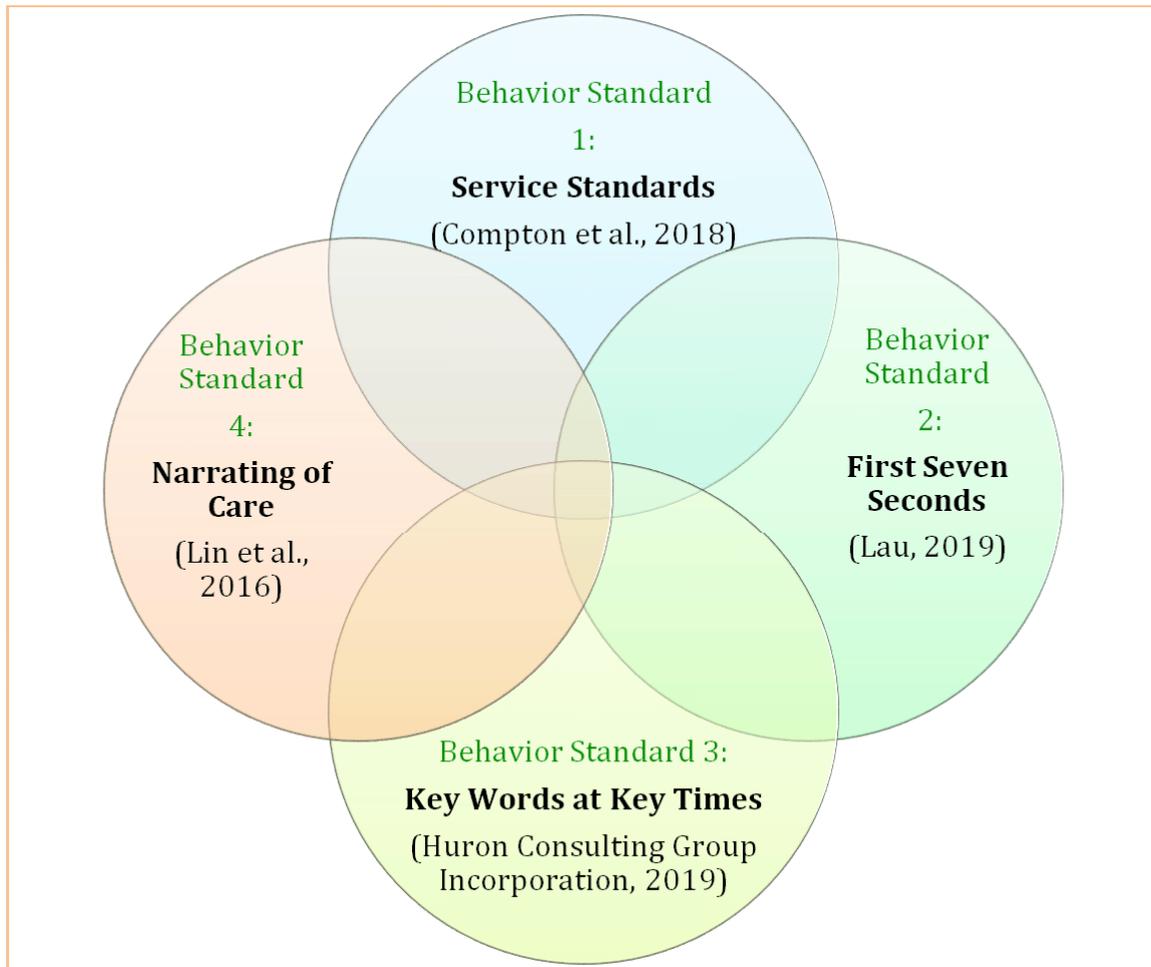
*Behavior Standard 1- Service Standards:* During the lecture, the project lead introduced the service standards to set a code of conduct, whereby nurses signed an agreement/attestation to clarify purpose and accountability (Appendix B).

*Behavior Standard 2- First Seven Second:* The project lead emphasized

the importance of knocking (three times), smiling, and washing of hands before and after entering the room. It is expected that the nurses purposely verbalized the act (Script: Preferred Name, I'm washing my hands).

*Behavior Standard 3- Key Words at Key Times:* The project lead highlighted the three nursing communication domain questions (treating with courtesy and respect, listening carefully, and explaining things clearly) using buzz words. The buzz words were intended to create a recall effect with patients. The project lead used a poster that was affixed in every patients' rooms. The expectation was for nurses to read the items in the poster slowly and clearly while their hands are pointing on the buzz words during the middle and last hour of the shift (twice-a-day). In addition, the nurses thanked the patient for being able to care for them.

*Behavior Standard 4- Narrating of Care:* The nurses were expected to announce the words *what and why* when doing a procedure or when educating patients. The verification of understanding will follow by asking the patient (Script: "Am I clear?" or "Is there anything you need further explanation?"). If the patient expressed understanding, the nurses asked the patient to repeat important information as part of the teach-back protocol. The nurses again thanked the patient for being able to care for them.



**Figure 2.0:** Behavior Standards

### Phase 3: Feedback Phase

Upon completion of the one-hour lecture session, simulation through role-playing commenced (Appendix D). Four simulation booths were used. The four medical center leaders/human validators observed the nurses role-playing behavior standards. The nurses stood in line and were given the observational tool (data collection checklist) prior to entering the room (Appendix E). The nurse carried the form upon entry to every booth and was signed off upon completion. The human validator gathered information on what aspects of the behavior standards needed additional coaching and reinforcement. The nurses were coached timely before proceeding to the next booth.

### Phase 4: Evaluation Phase

Upon completion of the lecture and simulation, validation followed from September 1 to November 20, 2020 to monitor the retention of learning. The validators, with the help of the project lead, observed the nurses executing the behavior standards in the unit and gave timely feedback and coaching to reinforce the behavior. The validators gathered additional information using the same data collection checklist, on what aspects of the behavior standards needed reinforcement. On November 11-13, 2020 the nurses again completed the Caring Efficacy Scale tool post-intervention. Reflective debriefing (four sessions; two hours each session) occurred on November 20, 2020 to gather feedback regarding the implementation of the behavior standards and to monitor nurses' readiness on implementing the second nursing communication bundle element (patient-focused handover).

### Study of the Intervention

The average number of nurses participating in every shift (12-hour shift every day) on this QI project varied between twelve and thirteen, including one charge nurse. The project was conducted over duration of three months. Pre-baseline data using the CES tool was collected and compared from the post-implementation data period using Excel® software. Aside from using the survey tool, various strategy building techniques were used as an approach to assess the impact of the intervention which included observation, validation, and managing performance. Observation focused on skill building through (timely and face-to-face) coaching to achieve and execute the desired behavior. Validating and managing performance were accompanied by controls (data collection checklist) to ensure the implementation of the plans and evaluation of results. Reinforcement required a thorough assessment of the results of strategic planning and involved re-thinking past practices and building effective, innovative, and sustainable models. Following a collaborative planning session with the nursing leadership team, the QI project was implemented for duration of three months.

### Measures

The project lead trained the director of care experience, the unit manager, director of performance improvement, and director of care experience on the observation and validation process. They observed and validated the nurse role-playing and performing the behavior standards and gave timely feedback. These community hospital leaders gave the nurse a copy of the observation (data collection checklist)

form/tool after each observation. The nurse integrated the suggestions from the validators. In the process, the validators provided additional coaching and discussion of practice with feedback. The adoption of the behavior standards was audited by the aforementioned leaders five times a week for 12 weeks using the same data collection checklist reflecting the newly adopted process. Following the completion of data collection, data analysis commenced.

The CES tool examined nurses' confidence in his/her ability to express a caring orientation and establish a caring relationship with patients. It measured caring attitudes, skills, behaviors, and barriers on a six-point Likert scale with a self-reporting format (Coates, 1997). This 30-item tool was guided by theories from both social psychology and nursing care theory. It is one of the few caring measurement tools that offered content validity and reliability with reference to the carative factors in Watson's theory (Sitzman & Watson, 2019). The tool has been tested for validity and reliability for over 24 years (Aviles Gonzalez et al., 2019) with an over-all Cronbach's alpha coefficient of .856 (Reid et al., 2015).

### Analysis

The pre-and post-implementation CES survey results that was completed by the same group of nurses were manually entered onto the Excel® software and then double-checked or reviewed for accuracy 100% of the time during the analysis. Responses were coded so that "strongly agree" was entered as +3 and the "strongly disagree" response was entered "-3." Scores for questions that were rated in the negative sense/scale were reverse coded so that the totals across items did have statistical meaning. The average (mean) of the CES scores from the group were compared pre-and post-intervention. The possible total group score was 90. The CES score of less than 60 points suggested a 'low' caring efficacy level, 61-80 suggested an 'average' caring efficacy level, and 81 or more suggested a 'high' efficacy level. The analysis focused on the CES tool questions 1, 2, 7, 14, 15, 26, 28, and 30 (8 of 30 items) as they strongly related to the interventions implemented in the unit.

The distribution of the CES tool was anonymous to ensure the confidentiality of the participants. The CES tool included nurses' demographic information including years of nursing experience, shift work, and the total number of patients cared for in a given shift to assess the impact of these variables on how nurses communicated with their patients. This demographic information was collected from the nurses on the initial paper-based survey. The database was created with assistance from the Pennsylvania State University statistician. A one-tailed independent t-test two sample assuming equal variances was used to compare the mean scores for the same group of nurses in the same environment on two different occasions.

In detail, the project lead, and the director of the care experience constantly reminded the nurses to complete and answer all 30 survey questions with a great deal of accuracy and precision. In handling missing data, the project lead left out nurses with incomplete surveys from the final analysis. This ensured that everyone was on a level playing field and eliminated the need to fill in any missingness using a statistical method such as imputation, regression, likewise or pair-wise deletion.

## Ethical Considerations

The project was submitted to The Pennsylvania State University Institutional Review Board (IRB). Site approval between the PSU College of Nursing and Mission Community Hospital was obtained. A letter of support was secured from the site mentor prior to the implementation of the QI program. Only aggregated and de-identified data were reported in the quality improvement project. There was no identifying staff information collected. The project did not involve the collection or use of identifiable individual private information. Data collected did not involve any medical records, charts, or any other patient's private information. The project did not pose any additional risks (physical risks and/or risks of confidentiality breach) or burdens on the nurse beyond routine nursing care. Completed surveys were stored on a flash drive that was stored on the project lead's password protected storage drive.

## Results

Over the course of the quality improvement initiative, 48 nurses participated and completed the pre-CES tool, demographic survey, and the post-CES tool. All 48 nurses (total population: 48 nurses) comprehensively answered the three demographic and CES survey questions. The analysis of the surveys and demographic questions enabled adequate evaluation of the intervention and necessary modifications.

### Nurse Demographics

Demographic data included shift worked, years of nursing experience, and the average number of patients cared for within the shift (Table 2). Fifty-six percent of the nurse participants worked the day shift. Most of the nurses (n=20) have one to five years of nursing experience and their average number of patients cared for within the shift was four patients (n=24).

**Table 2:** Nurse Demographics

	N	n (%)
<b>Shift Worked</b>		
7a-7p	27	56%
7p-7a	21	44%
<b>Years of Nursing Experience</b>		
New Grad	7	14%
1-5 years	20	42%
6-10 years	9	19%
11-15 years	4	8%
>16 years	8	17%
<b>Average Number of Patients Cared for within the Shift</b>		
4 patients	24	50%
5 patients	17	35%
6 patients	3	6%
7 patients	1	2%
>8 patients	3	6%

## Caring Efficacy Scale

Association between the pre- and post-evaluation of caring efficacy proved indistinguishable. Pre-intervention data were collected from 48 nurses on August 25-28, 2020 and post-intervention data were aggregated on November 11-13, 2020. Overall, caring efficacy scale scores improved by 14% (Table 3).

**Table 3:** Caring Efficacy Scale Pre-and Post-Intervention Scores

	Pre-CES Score	Post-CES Score
48 nurses	56.69	70.27

Note. The maximum CES tool score was 90.

As stated previously, a one-tailed independent t-test two sample assuming equal variances was used for the analysis. The results were statistically significant with a noted difference between the pre-intervention (mean = 56.69) and post-intervention caring efficacy scale (mean = 70.27) with  $t(48) = 1.66$  (is the value of t statistics calculated by Excel<sup>®</sup>) and  $p < .0001$  (3.8475E-10). Similarly, when the comparison was made between the responses with the eight CES questions (Table 4) a statistical significance was noted between the pre-intervention (mean = 17.33) and post-intervention (mean = 20.75) with  $t(48) = 1.66$  and  $p < .0001$  (5.6504E-18).

The eight CES questions include: (a) Q1-*I do not feel confident in my ability to express a sense of caring to my clients/patients*; (b) Q2-*If I am not relating well to a patient, I try to analyze what I can do to reach him/her*; (c) Q7-*It is easy for me to consider the multifacets of a client's/patient's care, at the same time as I am listening to them*; (d) Q14-*I use what I learn in conversations with clients/patients to provide more individualized care*; IQ15-*I don't feel strong enough to listen to the fears and concerns of my clients/patients*; (f) Q26-*I often find it difficult to express empathy with clients/patients*; (g) Q28-*When a client/patient is having difficulty communicating with me, I am able to adjust to his/her level*; and (h) Q30-*I don't use creative or unusual ways to express caring to my patients*.

**Table 4:** Caring Efficacy Scale (CES) Tool: Eight Survey Questions

CES Question Number:	Pre-CES Score	Post-CES Score
1,2,7,14,15,26,28,&30	17.33	20.75

Note. The table demonstrates the total scores of the eight CES questions pre-and post-intervention implementation. Responses were coded so that "strongly agree" was entered as +3 and the "strongly disagree" response was entered "-3." Total score for the eight CES survey questions was 24.

Although the results were statistically significant, the clinical significance must be considered. The mean difference of +3.42 (20.75-17.33 of 24 points) suggested a significant improvement in the responses to the eight CES question post-intervention. The results depicted an association existing between caring efficacy, behavior change/modification, and purposeful delivery in how care is perceived by patients. Recognizing the importance, ease of application, and the science behind the behavior standard interventions, consistent and

authentic execution can directly influence the care provided to the patients. Thus, results suggest a clear significance of the intervention and the advisability of evaluating sustained application and effectiveness of the intervention. The nurses completed the pre-and post-CES survey with great deal of precision and detail, thus no missing data was noted.

## Discussion

### Summary

The healthcare industry has undergone an unparalleled change from being a provider-focused to a service-driven industry (Allenbaugh et al., 2019). Hospital organization adapted quickly to regulatory changes and responding to the challenges of financing healthcare. These challenges (reimbursement models, healthcare delivery models, and value-based outcomes) empowered the leadership in the community hospital to manage a variety of demands for better healthcare service using specific key drivers/strategies that improved the overall patient satisfaction scores and to learn balancing cost and effectiveness to thrive in challenging situations. When applied efficiently and responsibly, these strategies engaged the best that all health care providers have to offer and set the stage for positive inclusion of the consumer in the care experience.

Prior to the implementation of this project, there was not a consistent structure, strategy, and process for nursing communication. Using Kurt Lewin's change theory provided a framework that facilitated the implementation of this quality improvement initiative. It was important to follow the steps stipulated in the theory to ensure adherence to the newly established delivery of care approach and for a better understanding of achieving the desired outcome. This project led to an improved change in the nursing culture of the medical-surgical unit, with nurses understanding the importance of the way they communicate and how words create an impact on every patient's experience. The nurse's vision became their voice, their course of action, and their way to a systematic and purposeful communication.

The project used an early evidence-based patient service model that enhanced the care experience using standardized service behaviors. Through a combination of behavior analytics and strategic insight management, the nursing communication bundle (particularly behavior standards) delivered awareness and guidance that gave nurses a competitive edge in transforming the patient experience. The project created an environment of exemplary care with a primary focus on nursing interactions and communication with patients and other stakeholders. Effective communication through the use of behavior standards required health care personnel to consistently apply different skills like caring communication skills (with respect and courtesy), a value-based impression (knocking on the door, smiling, and washing of hands), and narrating of care (explaining the what and why). Generating process specifications eliminated inappropriate variations in care delivery among the nurses. With new Medicare criteria regarding customer satisfaction, organizations that are using standardized service behaviors (e.g., nursing communication bundle) produced an environment that supports excellence in practice (CMS, 2018).

Results of this quality improvement project enriched the nurses with confidence and knowledge to purposefully use behavior standard communication techniques that emit caring efficacy to patients which was a specific aim identified for this project. As a potential added benefit, based on the post-CES survey, nurses' felt confident in their ability to express a sense of caring to the patients, connected, and listened well with their patients, learned in conversations with patients to provide individualized care, expressed empathy, adjusted to patients' level when the difficulty of communication was experienced, and used creative ways to express caring behavior to patients.

The QI project created a drive for culture change and innovation by engaging nursing staff to apply proactive and prescriptive actions aimed at achieving a superior patient care experience by improving the nursing communication process. The behavior standards promoted effective patient care management achieved through patient-centeredness, evidence-based operational changes, and the use of an innovative patient experience strategy that enhances nursing communication. These behaviors contained a blueprint that ensured all nursing patient care domains within the care experience journey were represented and interjected with new views into considerations of major changes in the stream of healthcare.

## Interpretation

The purpose of this intervention was to evaluate the effectiveness of behavior standards on nursing communication and the caring efficacy of nurses who work in a medical-surgical unit. Notably, the greatest measure of success was seen through the spread of the behavior standards in nursing care delivery, and this became a significant step for the organization as it moved towards service excellence. The results of this quality improvement project correlated with similar studies that supported the positive impact of behavior standards on nursing communication and caring efficacy (Allenbaugh et al., 2019; Brewer and Watson, 2015; Compton et al., 2018; Townsend-Gervis et al., 2014). Townsend-Gervis et al. (2014) suggested the importance of consistency, structure, standard, process, and repeatability of communication in a shared understanding of the patient and plan of care, resulted in improved patient satisfaction and clinical outcomes. The overarching discussion in similar research emphasized the essential aspects of the human caring theory using Watson's work in providing nurse leaders the opportunity to assess and evaluate the effectiveness of communication strategies and authentic delivery of care in professional practice environments (Brewer & Watson, 2015). To be successful, nursing communication and interaction requires authentic presence-ways of being reflective, sensitive, and present to every patient encounter every moment every time (Brewer & Watson, 2014).

The impact of the project on the nurses and the organization (system) was meaningful and widespread. The nurses incorporated caring language in every patient interaction purposefully and valued technical skills imparted during the simulation/role-playing as instrumental in enhancing caring efficacy. The dimensions of the rationale and theoretical representation of the project differed from "nurse to nurse," "nurse to patient," and "nurse to the organization"

in certain ways noted by the participants. The tenets of "nurse to nurse" expressed the ability of nursing staff to care for, empathize, understand, and respect other nurses and themselves. "Nurse to patient" emphasized the vitality of showing interest in the patient's perception of care, intentional presence, actively listening to expressed words, knowing what is important for the patient, validating patient's understanding through feedback, and coming to know every patient as unique individual. "Nurse to organization" empowered nurses to participate in an environment that allowed them as professionals to understand policy/regulations and quality initiatives, attain adequate skill sets appropriate to the changing practice, and be respected by the organization as leaders in care. Hardwiring proven systems of best practice, such as the behavior standards, brought consistent patient satisfaction results and measures of clinical excellence.

The reasons for any differences between observed and anticipated outcomes included observer bias (the nursing staff knows they are being assessed and disclosure about observation activities), specific characteristics of nurse-patient interaction (factors related to patients' clinical condition, emotional stability, and content), and observations of behavior that are favorably and unfavorably contaminated by other characteristics of the situation, such as acuity of the patient, average daily census, and the nurse-patient ratio at a given time period. This project also showed that with the right collaborative focus between the nurse leader and nursing staff, nursing communication can be affected in real-time with a focus on the domains of the nursing communication bundle. Finally, by establishing a process for better nursing communication, the project lead reinforced findings from Briggs et al. (2018); Bumpers et al. (2019); Kline and McNett (2019); and Riebling et al. (2019) concluding that using a communication bundle strategy improves nursing communication skills, thus positively impacts the overall patient experience. The opportunity cost in implementing the QI program was associated with the loss of potential gain from CMS reimbursement, more so the impact of an improved nursing communication process related to quality, safety, and experience in patient care delivery.

## Limitations

When designing a quality improvement project to improve the nursing communication process, a definitive intervention to consider is the possibility of controlling for confounding variables that can impact the process. Some of these variables in the project included the strength, commitment, and skill sets of the unit leadership, the organizational culture, quality improvement efforts with nurses of various backgrounds (experience and level of exposure), and the effects (fear, anxiety, uncertainty, and emotional stability) of the current pandemic environment on the staff. An important consideration before attempting the changes described here is the readiness of the staff on the unit and alignment of several initiatives that were started prior to this project to increase efficiency and promote value congruence. Value congruence and alignment can be noted when the nursing staff expresses a positive feeling upon encountering others who exhibit values like their own.

Nursing staff may need training and collaborative team-building

development opportunities to facilitate an atmosphere of camaraderie and a seamless flow of communication between other healthcare providers to gain the most benefit from the efforts. Additionally, to maximize the benefit of evidence-based nursing communication initiatives, a compiled improvement strategy should focus on methodological and systematic implementation of all the bundle elements. Institutional implementation involves focusing on one bundle at a time on a quarterly basis to assess areas of improvement and opportunity before moving to the next bundle element. Peer-to-peer observation and validation can also enhance team commitment, ownership, and accountability. Evaluating their peers in the performance of the expected task might help enhance their improvements. A communication initiative for the ancillary team (physicians, certified nurse assistance, and unit clerks) both in nursing and non-nursing inpatient and outpatient departments would be helpful in spreading, sustaining, and optimizing care delivery.

The new process does not currently incorporate the use of the admission (welcome) and discharge parade as deemed important considering the insight of the project lead. These extended services set the tone and validates the culture of the unit. The admission parade creates the initial seven-second impact in the care experience journey while the discharge parade creates the last thirty-minute's momentum for the patient satisfaction survey. Analyzing the previous experiences of the project lead, the admission-discharge parade program is a product of structure, content, style, format, and concept. Awareness of the role of each participant (nurse, nurse assistant, manager, and admitting physician) will result in authentic scripts that are targeted to the patient and the goal of the program. These elements, plus an opening (all identified participants lined-up during the patients' initial entry to the room, introduce their roles and responsibilities, and outline expectation regarding care) that grabs the patient's interest and closing (all participants express gratitude in choosing the organization for all the patient's healthcare needs) that ties it all together are vital to the success of the nursing communication initiative.

A larger sample size, facility-wide implementation, or a longer implementation time frame encompassing the entire nursing communication bundle may have changed the results of the QI project. Other limitations in this project include the single-unit and specific non-COVID 19 patient population examined. It is possible that a different sample of patients in other specialty units may have rendered different findings. Regardless of the limitations, the notable improvements in the nursing communication process should not be discounted given the unprecedented situation the healthcare environment faced. The patient satisfaction is implied and anticipated based on literature support, but the project did not measure patient satisfaction scores.

## Conclusions

The nursing communication bundle exercised the ability of staff to treat patients with dignity and respect, behave within an institutionalized culture of expected norms, and communicate systematically to provide high-quality care. The wider impact of the challenge focused on positive and negative stakes. The initiative positively influenced an organization

to assimilate best practices and reconsider its values toward multiple key stakeholders (patients, regulators, and providers). It also facilitated organizational development using a people-and value-based approach involving a long-range behavioral strategy for understanding, developing, and changing an organization's care delivery structure to improve its effectiveness. Adversely, conglomerate care delivery diversification might add untoward consequences through forwarding and concentric integration of strategies, e.g., patients might perceive the nursing communication bundle to be lacking emotional ingenuity. The development of the care experience strategy outlined in the initiative supported the realization of a change management plan that highlighted a personal and professional framework for communicating and dealing with patient care adversities.

When considering dissemination, replication of this project could be enhanced by institutionalizing or adopting one bundle element at a time (incremental/institutionalized roll-out), then methodologically validate quarterly to monitor sustainability and spread before moving to the next bundle element. In addition, creation of a curriculum that cycles through the bundle as an integral part of the annual nursing competencies and performance evaluation will be helpful in achieving sustainability. Ongoing evaluation could be performed at yearly employee evaluations conducted by the manager of each nursing unit. Dissemination and sustainability of the intervention can be achieved through collaboration with the leaders in the education and the performance improvement department.

The QI project aimed at supporting caring efficacy in nurses who work on a medical-surgical unit through standardization of communication. The results of the project suggested using behavior standards was an effective intervention. The nursing communication bundle initiative became an integral part of the accountability process that systematically eliminated unacceptable staff behaviors, aligned judgments/attitudes, and established a modest, standardized base of information for patient care experience building. The initiative worked on instilling accountability in all medical centers' staff using the behavior standards. These behavior standards are caring communication models that affect quality, service, standards of care, market share (customer experience), and safety. They are considered mental models and skill sets that drive meaningful communication. Behavior standards enhanced the nursing communication process, thereby contributing to improved quality of care and service delivery.

The replication of the nursing communication bundle program is in process at an organization level. This will allow the nursing communication interventions to be applied to a larger group of nurses in different practice specialties/settings. Increasing the number of departments included in the program would increase generalizability and promote a wide-scale improvement in care experience. Synthesizing the findings is the initial step in further understanding the role of behavior standards in the overall patient experience, which is not just a service quality-based script/intervention but is an intentionally and meaningfully invested strategy to achieve better outcomes in the patient satisfaction arena.

## About the Author

Dr. Glenn D. Pascual is a healthcare leader of 22 years. A combination of strong Ivy League education, outstanding work experience, award-winning performance, and the right leadership/soft skills make an outstanding and highly desirable leader, innovator, motivator, and change agent. In November 2020, he was named as Gawad Amerika's "Hero Frontliner Excellence in the field of Hospital Administration and Management". This most recent honor brings to 61 the total number of state, regional, national, and international awards bestowed on Glenn in the past 12 years. He is currently completing his Doctor in Nursing Practice in the prestigious Pennsylvania State University. To date, this well-known leader has earned two doctorate degree, three executive master's degree, and three board certification including a Fellow in the American College of Healthcare Executives. His best practice innovation awards highlighted his passion for patient care and care experience delivery. Dr. G as everyone calls him believes: "In order to succeed, your desire for success should be greater than your fear of failure".

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