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Implementation of a Patient-Centered Communication Model in the Emergency Department

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Implementation of a Patient-Centered Communication Model in the Emergency Department

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Abstract

The objective of this scholarly project is to determine the impact of patient-centered communication education in an emergency department (ED) on the perception of workplace safety. The ED is a vulnerable setting and susceptible to workplace violence (WPV) due in part to increasing numbers of patients presenting to EDs with primary psychiatric complaints. High-quality patient-staff interactions correlate positively with better treatment outcomes. Patient-centered communication skills can be taught, and patients have similar expectations of what patient-centered communication means no matter their diagnoses. The purpose of this quality improvement project was to conduct patient-centered communication education with nurses, nursing assistants, and security officers working in an ED focusing primarily on communicating with individuals who have a mental illness. The education development was guided by the Four Habits Model framework, and was implemented in a Plan, Do, Study, and Act manner. A pretest/post-test design was used to evaluate their learning, and an assessment of the perception of workplace safety post-education was done. Results were analyzed using quality improvement methodology. The DNP student also conducted informal interviews with the ED and security staff post- implementation. The purpose of the interviews was to gain a better understanding of what went well and what barriers got in the way related to communicating with patients with a mental illness. This was done in order to further develop the educational content.

Keywords: patient-centered, communication, approach, therapeutic, mental illness, psychiatric, workplace violence, emergency departments.

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Executive Summary

Patient-centered communication has been associated with visit satisfaction, recall of medical information, medication adherence, and adoption of healthful lifestyle behavior. Additionally, patient-centered communication, particularly when used with patients with a mental illness, has been associated with improved care for patients and increased staff comfort. Approximately 55% of Emergency Department (ED) nurses reported exposure to physical or verbal abuse within the previous 7 days. Moreover, many clinicians cite a lack of training and skills needed to communicate effectively as a reason for patient agitation.

Problem Statement

The rate of violent victimization for nurses is increasing and issues with communication persist. There is a need for a fundamental shift in the nurse-patient relationship to facilitate patient collaboration in their care and decrease patient frustration. The purpose of this scholarly project will be to address the identified gap in current practice related to patient and nurse communication.

Evidence-Based Initiative

The aim of this project was to design and implement patient-centered communication in an effort to improve the overall perception of workplace safety in the ED. Because health care consumers have different perspectives about their interactions with health care providers, assessing for patterns of beneficial communication styles was important. In order to present a current state of knowledge about patient-centered communication and synthesize the findings related to health care outcomes, a review of pertinent literature was completed.

Fourteen studies met all eligibility criteria for the review. Findings from the research indicated that individuals accessing care in various settings, including EDs, inpatient, or

outpatient settings had similar expectations about the importance of effective communication. Additionally, the findings were similar across patient populations and noted the importance of establishing rapport, eliciting patient concerns, demonstrating empathy, and involving patients in their treatment plan.

Conceptual and Implementation Models

The conceptual framework that was used to guide the patient-centered communication intervention was The Expanded Four Habits Model. The Expanded 4H Model (X4H) builds on the original 4H model and the Six Skills model and has been designed to improve interactions with patients in emotional distress or with other psychosocial concerns. The implementation model that was used to guide the patient-centered intervention methodology was the Institute for Healthcare Improvement's (IHI) Model for Improvement (MFI), which includes a Plan-Do-Study-Act format (IHI, 2017).

Need and Feasibility Assessment

A Strengths-Weakness-Opportunities-Threats (SWOT) analysis was completed to assess support for improving care of patients with mental illness, specifically in the ED. The SWOT analysis identified real and potential strengths, weaknesses, opportunities, and threats. Some of the key strengths were that the organization consisted of highly trained, motivated, and skilled leaders, and had a strong shared governance model. Some key weaknesses included inconsistently trained staff and leaders in the care of patients with mental illness and that psychiatric patient volume was increasing.

Project Plan

A patient-centered communication education focusing primarily on patients with a mental illness was conducted with nurses, nursing assistants, and security officers working in an ED. A

pre and post-test was given to all participants and was used to evaluate learning. The DNP

student conducted a formal post-intervention survey using Survey Monkey and informal

interviews with the staff to assess whether the objective was met. The interviews were succinct

and included three rating questions and one open ended question related to operationalizing

patient-centered communication with patients who have a mental illness.

The design of the project consisted of meeting with the ED team to design the education,

which included video vignettes involving additional frontline staff. The project was then

implemented in six educational sessions which included a pre and post-test. A post-intervention

was sent via email using Survey Monkey two weeks after the last educational session. Results

were analyzed and presented to the ED leadership team.

Project Results

The participants were a relatively young group with most participants between 18 and 29

years of age (N=83). There were no participants over the age of 59 years. Years of experience

ranged from 0.5 to 30 years, with a mean of 5.1 years. The mean pre-test score was 5.4 with a

range from 3 to 9. The mean post-test score was 8.2 with a range from 4 to 9. The post-test

scores increased by 34% as compared to the pre-test.

Approximately 25% of participants (n=21) responded to the post-intervention survey.

Almost all of the participants, 90.48% (n=19) found at least some value to the education. All of

the participants, 100% (n=21) were able to use the tools in practice. The majority of participants,

66.66% (n=14) experienced at least some improved perception of workplace safety.

Nursing Implications

Several participants commented that they did not feel safe enough to communicate

directly or share feedback with their peers in the ED. This information was shared with the ED

leadership team, who will be using this information to guide further projects related to improving the culture of safety on the unit. The timeline of this project did not allow for adequate examination of patient and staff outcomes. Further monitoring of patient experience data, rate of restraint use, and occurrences of workplace violence would be beneficial to determine any additional impact of the project intervention. Further innovative approaches and regular on-going supervision will be required to ensure a safe environment for patients and nurses.

Dissemination Plan and Recommendations

Given the heightened awareness related to workplace violence, and the positive outcomes from the patient-centered communication education in the ED, the next step will be to implement the education throughout the larger organization. A copy of the scholarly project will be provided to the hospital site, which will include all of the electronic educational content. A copy of the project will also be uploaded into Grand Valley State University ScholarWorks.

Conclusion

A group of nurses, nursing assistants, and security officers took part in a project to enhance their communication skills. They were able to reflect more deeply on their relationships with patients and adopt principals of patient-centered communication into their everyday interactions with patients. Participants felt that the education was valuable. They acknowledged that they were able to use the tools in their practice. Providing patient-centered communication education to all ED and security staff led to an improved staff perception of workplace safety.

Implementation of a Patient-Centered Communication Model in the Emergency Department

Patients expect to be treated with empathy and respect by nurses and physicians, no matter their reason for accessing health care services (Haron & Tran, 2014). When health care providers are able to listen and speak effectively to patients, they minimize patient frustration and improve engagement (Frankel & Stein, 1999). Patient-centered communication has been associated with visit satisfaction, recall of medical information, medication adherence, and adoption of healthful lifestyle behavior (Zolnierek & Dimatteo, 2009; Griffin, Kinmonth, Veltman, Grant, & Stewart, 2004). Additionally, patient-centered communication, particularly when used with patients with a mental illness, has been associated with improved care for patients and increased staff comfort (Kemp, Rooks, & Mess, 2009).

One patient group that is significantly impacted by disjointed communication is comprised of individuals with medical and mental health conditions. Health care providers caring for individuals with mental illness rarely communicate, share, or collaborate about the plan of care, contributing to patient frustration (Laderman, 2015). Employing effective communication strategies is essential when attempting to positively impact overall health for individuals with mental illness.

Mental Illness and the Emergency Department

In the 1950s, there was a push for deinstitutionalization and a move towards community-based care. While this idea was well intentioned, the resulting problem was that sufficient resources were not put in place to care for mentally ill individuals with more severe and urgent needs (Zun, 2011). Substantial declines in mental health resources have burdened EDs with increasing numbers of patients with mental health issues (Zun, 2011).

Patients waiting for inpatient psychiatric beds remain in the ED three times longer than non-psychiatric patients, averaging 7 to 11 hours, and can take more than 24 hours when patients require transfer to an outside facility (Sharfstein & Dickerson, 2009). People in crisis often access the ED because they do not know where else to go, only to wait hours and sometimes days for psychiatric treatment (American College of Emergency Physicians [ACEP], 2014). The Emergency Nurses Association (ENA) has identified that delays in service, crowding and uncomfortable surroundings and lack of staff training are risks for violence (Emergency Nurses Association, 2008).

Workplace Violence and the Emergency Department

Improving care for patients and increasing staff comfort are compelling reasons to change the way health care providers communicate. Results of the Bureau of Justice Statistics National Crime Victimization Survey found that from 2005 to 2009 the annual rate of violent victimization for nurses and physicians was 8.1 and 10.1, respectively, per 1,000 workers compared with 5.1 for all occupations (Harrell, 2011). Approximately 55% of ED nurses reported exposure to physical or verbal abuse within the previous 7 days (ENA, 2011). Moreover, many clinicians cite a lack of training and skills needed to communicate effectively as a reason for patient agitation (Loeb, Bayliss, Binswanger, Candrian, & Degruy, 2012).

Studies addressing interventions to reduce violence in EDs have focused on ways to manage aggression; however, training must also include ways for staff to avoid unintentionally contributing to patient frustration which can lead to aggressive behaviors (Anderson, FitzGerald, & Luck, 2010). The emphasis of this project will not be training nurses on how to manage aggression; instead the focus will be training nurses on how to communicate with patients in a

way that allows rapport to be established in the beginning, minimizing patient frustration and increasing patient engagement.

Definition of Terms

Patient-Centered

The term "patient-centered care" has been brought into discussions related to health care quality. Patient-centered care has been identified in the Institute of Medicine's (IOM) Quality Chasm report as one of six key elements of high-quality care (Institute of Medicine, 2001). Lost in many of the discussions, however, is what it means to be "patient-centered". For the purposes of this project, patient-centered will be defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring patient values guide all clinical decisions" (IOM, 2001, p.3).

Workplace Violence

Additionally important to define is the term "workplace violence (WPV)". Violence in the workplace can take on different meanings for different people. For the purposes of this project, workplace violence is defined as "any act or threat of physical assault, harassment, intimidation, or other coercive behavior" (Harrell, 2011, p.2).

Problem Statement

The rate of violent victimization for nurses is increasing and issues with communication persist. There is a need for a fundamental shift in the nurse-patient relationship to facilitate patient collaboration in their care and decrease patient frustration. The purpose of this scholarly project will be to address the identified gap in current practice related to patient and nurse communication. A patient-centered communication education focusing primarily on patients

with a mental illness was conducted with nurses, nursing assistants, and security officers working in an ED.

The ED setting was chosen after reviewing the prevalence of WPV in EDs nationally and the increase in individuals accessing EDs with psychiatric complaints. People working in the ED were being abused verbally and physically consistently, and the responsibility of health care administrators to provide a healthy and safe work environment is a legal and ethical responsibility (Copeland & Henry, 2017). The focus of current practice has been training nurses on how to effectively manage patient aggression; however, this tactic alone is not resulting in decreased injuries (Anderson et al., 2010).

Establishing a sense of urgency for the change, forming a powerful guiding team, and establishing a clear vision was imperative to successful change implementation (Kotter, 1996). Gaining buy-in from key stakeholders was an essential first step to successful change implementation (Kotter, 1996). Meetings with ED leadership and frontline staff occurred to assess the most effective way for the team to receive the education and validate competency, collectively formulating a vision for the change implementation.   Sharing pre-intervention data related to WPV with the team and clearly explaining the rationale and goals of the project was the purpose of the first meeting.

The question that was addressed in this scholarly project was: Among patients with mental illness in the ED, does patient-centered communication education as compared to usual care improve the perception of workplace safety? Understanding that patient-centered communication improves overall patient outcomes (Kemp et al., 2009) and decreases patient frustration, implementing such a model would likely decrease patient agitation and improve staff perception of work place safety. The primary process intervention of this project was to design

and implement patient-centered communication training for ED nurses in a way that was

meaningful and sustainable.

Evidence-Based Initiative

The aim of this project was to design and implement patient-centered communication in

an effort to improve the overall perception of workplace safety in the ED. Because health care

consumers have different perspectives about their interactions with health care providers,

assessing for patterns of beneficial communication styles was important. In order to present a

current state of knowledge about patient-centered communication and synthesize the findings

related to health care outcomes, a review of pertinent literature was completed. Because of the

limited number of studies specific to patient-centered communication in the ED, the scope of this

review focused on the experiences of adults (18 years and older) in various health care settings,

including inpatient, outpatient, and emergency rooms.

Search Methods

The Cumulative Index of Nursing and Allied Health Literature (CINAHL complete),

Cochrane Collaboration, and PubMed databases were searched to identify studies that reported

on patient-centered communication interventions, with the parameters of the search from 2007-

2017 (Liberati et al., 2009). Refer to Figure 1 for a diagram outlining the literature search

methods.

```
177 studies identified through search strategy
20 Pubmed; 136 CINAHL; 21 Cochrane
n=177
                                        149 studies excluded by limits:
                                        date (2007-2017), English, peer
                                        reviewed, adult
Studies retrieved
n=28
                                        16 studies were excluded as
                                        ineligible on basis of
                                        inclusion/exclusion criteria
12 studies met criteria
                                        2 studies added by reference list
                                        checks
14 studies included in the final
review
n=14
```

Figure 1. PRISMA diagram (Liberati et al., 2009) Used with permission from BMJ Publishing Group Ltd. (see Appendix C).

Inclusion and Exclusion Criteria

In order to gain understanding about the most recent and relevant studies related to this topic, the parameters of the search contained studies from the past ten years. The search terms used in this review were patient-centered or therapeutic and were combined with communication or approach. Because there were several thousand articles identified in the initial search, and the focus of the review was specific to patients with a mental illness, further limitations were applied.

Since the focus of this review was on patient-centered communication used with adults, exclusion criteria eliminated any articles related to pediatrics. Studies from outside the United States were included if they were published in English. Other exclusion criteria included papers that did not investigate or report results concerning the aim of this review. The final 14 articles that met inclusion criteria included both systematic reviews and research articles that focused on patient-centered or therapeutic communication, provider-patient interactions, and communication skills training in adult patient populations.

Review of Patient-Centered Communication Studies

Fourteen studies met all eligibility criteria for the review. Based on Melnyk and Fineout-Overholt's (2015) hierarchy of evidence (Figure 2), there are three systematic reviews (level 1), one meta-synthesis review (level 1), five randomized control trials (RCTs – level 2), two controlled cohort trials (level 3), one qualitative study (level 5), and one evidence-based practice implementation study (level 6) included in the review.
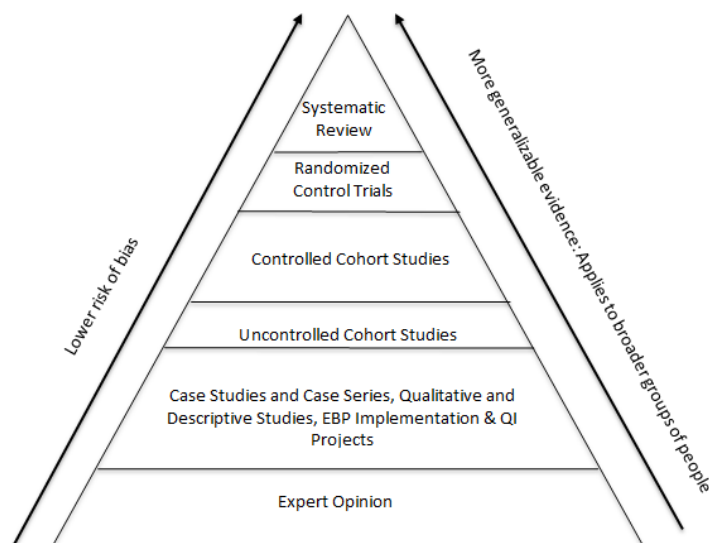
Figure 2. The hierarchy of evidence pyramid (Melnyk & Fineout-Overholt, 2015, p. 92). Used with permission from Wolters Kluwer Health (see Appendix B).

The findings of the review were categorized as (a) characteristics of patient-centered communication; and (b) studies related to communication training interventions. Refer to Appendix A for a more inclusive overview of the findings that will be presented. Information includes sample size, study design, experimental and control groups, intervention, and data analysis methods.

Patient-centered characteristics. Of the 14 studies included in the review, seven focused primarily on characteristics of patient-centered communication and their impact on patient outcomes, while the other seven focused on patient-centered communication interventions and training methods. Themes emerged from the studies related to patient perspective of effective communication. Seventy five percent of studies in three systematic reviews noted the importance of establishing rapport, eliciting patient concerns, demonstrating empathy, and involving patients in their treatment plan (Cleary, Hunt, Horsfall, & Deacon, 2012; Griffin et al., 2004; Newman, O'Reilly, Lee, & Kennedy, 2015).

In a meta-synthesis review of qualitative studies focusing on nurse-patient interactions on an inpatient psychiatric unit, 61% of the studies noted that the personal characteristics that are important to patients when establishing rapport were having a sense of humor, respecting patient's intrinsic humanity, being non-judgmental, having patience and perseverance, and providing internal calmness in the face of high stress (Cleary et al., 2012). Evident in the literature was that effective communication is comprised of much more than simply verbal communication. In order to decrease patient anxiety, health care providers must develop interpersonal calming when listening, understanding, and responding to patient concerns, especially when interacting with a patient in emotional distress (Cleary et al., 2012).

Most of the trials evaluated whether communication training led to specific outcomes (Cleary et al., 2012; Cousin, Schmid-Mast, Roter & Hall, 2011; Griffin et al., 2004; Hall, Gulbrandsen, & Hall, 2014). Findings suggest that communication skills training led to several objective and subjective health outcomes. Interacting with patients in a patient-centered manner led to significant improvements in health outcomes including increased satisfaction, functional status, quality of life, well-being, and decreased anxiety, depression, diabetes complications, hemoglobin A1C, and blood pressure (Griffin et al., 2004).

Hall et al. conducted a RCT that found that females performed in a more patient-centered way than males did, with the strongest difference in the emergency setting. Females were also more likely to display patient-centered communication characteristic, such as taking time to establish rapport, elicit patient concerns, demonstrate empathy, and involve patients in their care (Hall et al., 2014). Female physicians earned significantly higher patient satisfaction scores in the inpatient and emergency room settings. This study noted that physicians that displayed more patient-centered communication characteristics had higher patient satisfaction scores (Hall et al., 2014).

In a mixed methods, prospective, controlled cohort study, the authors conducted interviews with 72 inpatients of a large mental health hospital in Israel (Haron & Tran, 2014). The aim of the study was to identify the expectations patients with schizophrenia (who are not actively psychotic) have for their doctors and nurses and for how doctors and nurses should behave towards them in the context of a large mental health hospital (Haron & Tran, 2014). The main findings of the study indicate that patients expect staff to treat them with respect and as individuals and not merely as an illness; they expect to be involved in decision-making about their treatment, and expect that all hospital staff, especially nurses, to provide them with

emotional support (Haron & Tran, 2014). Being treated with respect and being involved in

treatment decisions are consistent with patient-centered communication skills (Lundeby et al.,

2015). These findings are consistent with results from other studies, supporting the notion that

individuals benefit from patient-centered communication no matter the diagnosis.

In a qualitative study, the aim was to develop a communication-centered model of shared

decision-making for mental health contexts. The main themes of the study included a) the value

of autonomy and empowerment; b) the importance of transparent communication; and c) valuing

each other's expertise (Mikesell, Bromley, Young, Vona, & Zima, 2016). These themes align

with components of patient-centered communication.

Summary. Individuals accessing care in various settings, including EDs, inpatient, or

outpatient settings had similar expectations about the importance of effective communication.

Additionally, the findings were similar across patient populations and noted the importance of

establishing rapport, eliciting patient concerns, demonstrating empathy, and involving patients in

their treatment plan. Lastly, themes emerging from the qualitative studies aligned with the results

from the quantitative trials further supporting the impact of patient-centered communication on

health care outcomes.

Patient-Centered Communication Interventions and Training Methods. Of the 14

studies included in the review, seven focused primarily on patient-centered communication

interventions and training methods, including two systematic reviews, three RTCs, one

controlled cohort study, and one evidence-based practice project.

Some of the main findings from the studies reviewed were that physicians and nurses

who received some sort of communication training intervention were significantly more likely to

elicit patient concerns and exhibit an overall patient-centered approach as compared to controls

(Dwamena et al., 2012; Helitzer et al., 2010; Passalacqua & Harwood, 2012; Rao, Anderson, Inui, & Frankel, 2007; Roter et al., 2012). The higher the intensity of the intervention, the more likely physicians were to exhibit specific patient-centered communication behaviors. Another statistically significant finding was that communication interventions resulted in positive effects on several health care outcomes. These outcomes include clarifying patients' concerns and beliefs; communicating about treatment options; levels of empathy; and patients' perception of health care providers' attentiveness to them (Dwamena et al., 2012).

Findings from the studies reviewed also suggest that different communication training methods can be effective in improving patient-centered communication skills. One successful training method was comprised of an all-day communication skills training, individualized feedback on videotaped interactions with simulated patients, and optional workshops to reinforce strategies for engaging patients (Helitzer et al., 2010). Another effective training method was based on the LEAPS framework, an acronym for listen, educate, assess, partner, and support (Cohen-Cole, 1991). The training was computer-mediated, and a questionnaire was given before and after the intervention to assess the impact on patient satisfaction (Roter et al., 2010). Consistent with other studies, Roter et al. (2010) found that communication skills acquired by physicians after training were associated with decreased emotional distress of their patients.

Another intervention that resulted in improved patient-centered communication behaviors of physicians consisted of a 3-day structured communication skills training (Maatouk-Burmann et al., 2015). The WEMS (waiting, echoing, mirroring, and summarizing) framework to enhance listening skills and the NURSE model (naming, understanding, respecting, supporting, and exploring) to foster empathic verbal skills (Langewitz et al., 2010) were used as the basis for the training intervention. The training resulted in immediate improved communication behavior of

physicians toward a patient-centered approach. This improvement was sustained three months later.

In an evidence-based implementation project, the authors tested the impact of an educational program on therapeutic communication skills of staff in acute care unit (Kemp et al., 2009). The main components of the training were therapeutic skills teaching, reflective diary, and practice tasks (Kemp et al., 2009). The participants expressed high levels of satisfaction with the teaching style of the program, specifically the role-play activities, the weekly reflection sessions, follow-up support between sessions, and the team approach to skills development. Participants also noted improved therapeutic communication skills after the educational program.

Summary. In conclusion, the main findings specific to communication training interventions were healthcare providers who received some sort of communication intervention were significantly more likely to exhibit patient-centered communication skills, whether it be physicians or nurses. The intensity of the intervention positively correlated with the likelihood that physicians were to receive high ratings of communication style. The findings also indicated that several different training methods were successful in leading to increased patient-centered communication skills.

<center>**Conceptual Models**</center>

The aim of this project was to design and implement patient-centered education in the ED. The Expanded Four Habits Model (Lundeby et al., 2015) was used as a framework when designing the project intervention. The Institute for Health Improvement's Model for Improvement (IHI, 2017) was used to guide the implementation of the patient-centered communication intervention in the ED.

Conceptual Framework—The Expanded Four Habits Model

The conceptual framework that was used to guide the patient-centered communication

intervention was The Expanded Four Habits Model (Lundeby et al., 2015). Refer to Figure 3 for

a visual representation of the model.
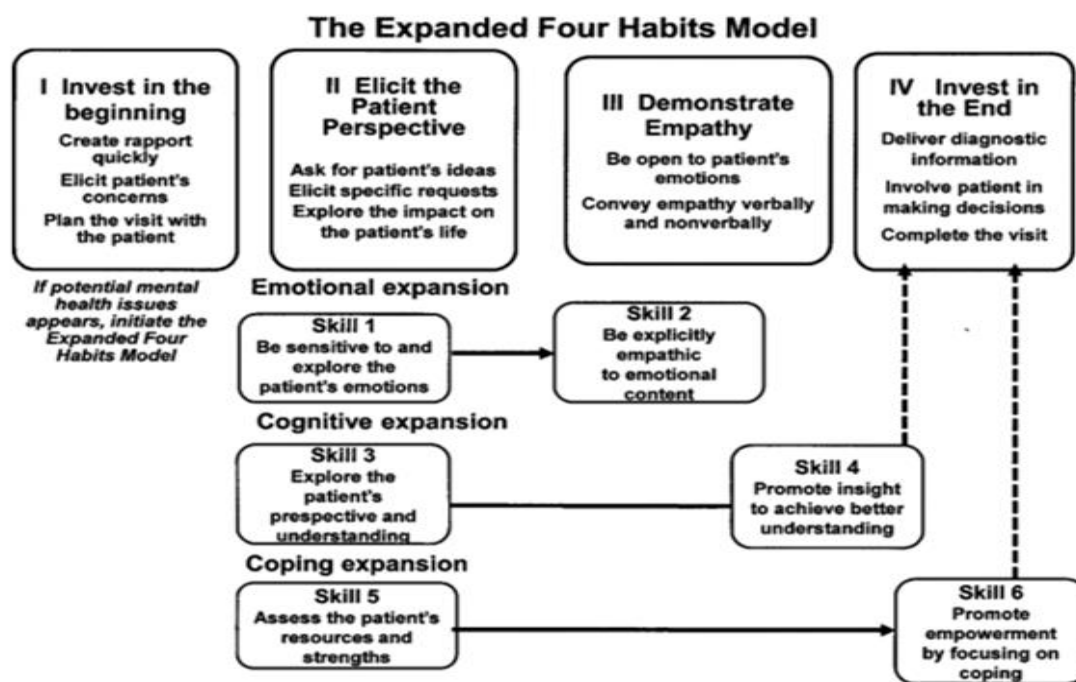
Figure 3. The Expanded Four Habits Model (Lundeby et al., 2015) The original Four Habits
Model constitutes the four upper boxes (Frankel & Stein, 1999). Used with permission from
Elsevier and Copyright Clearance Center (see Appendix D).

The model represents integration between the concept of Six Skills (Stensrud,

Gulbrandsen, Mjaaland, Skretting, & Finset, 2014) and the Four Habits Model (Frankel & Stein,

1999). The overarching goal of the Four Habits Model (4H Model) is to get the most out of every

clinical encounter (Frankel & Stein, 1999). The main elements of the model include a) invest in

the beginning; b) elicit patient perspective; c) demonstrate empathy; and e) invest in the end.

The overarching goal of the Six Skills Model is similar to the 4H model and is to obtain

rapport and secure an efficient and patient-centered interaction (Stensrud et al., 2014). The six

skills in the model are a) explore emotions; b) respond empathically; c) explore the patient's

perspective; d) provide insight; e) explore resources; and f) promote coping.

The original 4H model is anchored in patient-centered care, which is increasingly

becoming the expectation in healthcare (Lundeby et al., 2015). A report by the Institute of

Medicine (2001) notes that providing care using a patient-centered approach is central to closing

the quality gap between what is thought to be good health care and the health care that people

actually receive. The Expanded 4H Model (X4H) builds on the original 4H model and the Six

Skills model and has been designed to improve interactions with patients in emotional distress or

with other psychosocial concerns (Lundeby et al., 2015).

The X4H model includes an expansion of the original patient-centered Four Habits within

three key psychological domains: emotion, cognition and coping. There is one explorative and

one elaborative skill in each domain (Lundeby et al., 2015). As is the case with the original 4H

model, the expanded model represents both a model of communication and a scheme for

communication skills training, which is particularly relevant for this project.

Habit I. The elements of the X4H model include 4 habits and 6 skills. Habit I includes

establishing rapport with a patient, eliciting patient concerns, and planning the initial visit,

consultation, or interaction (Lundeby et al., 2015). If, during this initial component, mental

health issues appear, then the clinician would proceed and the expanded portion of the 4H model

would be initiated. A basic principle of the expanded portion includes therapeutic elaboration

when talking with a patient (Lundeby et al., 2015).

Habit II. Habit II, eliciting patient concerns, represents the explorative portion of the

patient interaction. The clinician asks for patient ideas, eliciting specific requests, and exploring

the impact of current health problems on their life. The expanded version includes more

expansive exploration of the patient perspective, using skills 1, 3, 5. These skills include exploring emotions, exploring the patient's perspective, and exploring patient's resources.

These skills are specific and helpful for patients in emotional distress. When an emotional concern is detected, the patient's distress should be acknowledged and responded to early in the sequence (skills 1 and 2). Then the patient's understanding of the problem should be explored (skill 3) before an alternative understanding may be discussed (skill 4) and the patient's personal resources and coping potentials are explored and elaborated on (skills 5 and 6) (Lundeby et al., 2015).

Habit III. Habit III, demonstrating empathy, is referenced throughout the literature and is something that patients perceive as being an essential component to the nurse-patient relationship. Both verbal and nonverbal communication techniques are important when demonstrating empathy. Cognitive empathy involves understanding other's internal states (Eisenberg, 2000) and can only occur when the empathizer is able to regulate his/her own emotions.

Habit IV. Habit IV, investing in the end, is the element of the model that focuses on sharing diagnostic information and involving the patient in decision making. The expanded model incorporates more tools to be able to effectively invest in the end. There is flexibility in the model as to whether Skills 4 (promote insight to achieve better understanding) and 6 (promote empowerment by focusing on coping) should be performed immediately after the exploration phase (Skills 3 and 5 respectively) or be delayed to Habit IV (Lundeby et al., 2015).

The clinician should not necessarily go through all six skills in the same consultation. The important feature of the model is that it provides the clinician with a series of tools to choose

from when handling difficult consultations. This framework was used as the outline for the

patient-centered communication education design.

Implementation Model

The implementation model that was used to guide the patient-centered intervention

methodology was the IHI's Model for Improvement (MFI). Refer to Figure 4 for a visual

representation of the model.
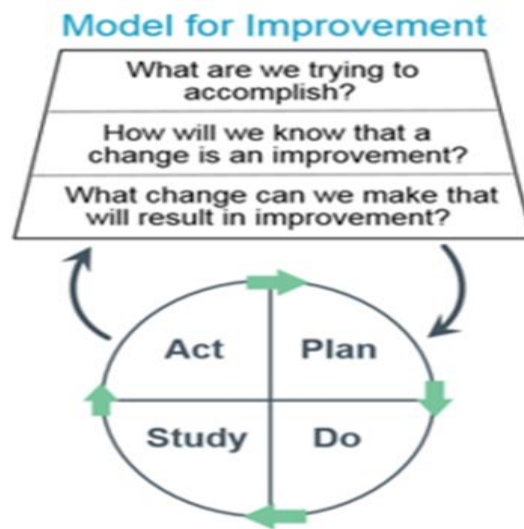
Figure 4. The Improvement Model (Institute of Healthcare Improvement, 2017). Used with permission from John Wiley and Sons and the Copyright Clearance Center (see Appendix E).

The Associates in Process Improvement developed the Model for Improvement, in

partnership with IHI. The MFI is a simple, yet all-encompassing tool that guides change

implementation in an accelerated manner. The model has been used in many quality

improvement studies to improve health care processes and outcomes (Hennessy & Dyan, 2014;

Polancich, Poe, von Hagel, & DeMoss, 2016; Kader, Eckert, & Toth, 2015).

Question component. The MFI consists of two components. The first component

addresses three questions, which do not have to be asked in any specific order. The three

questions include: (a) what are we trying to accomplish; (b) how will we know that a change is

an improvement; and (c) what change can we make that will result in improvement (Institute for

Health Improvement, 2017). The first question clarifies what problem the team is attempting to

solve by implementing a specific change. The objective of the intervention should be specific,

measurable, and should define which specific patient population or department staff will be

affected. This question was addressed more directly in an organizational assessment, which will

be reviewed later in the paper.

The second question addresses the specifics around metrics and how each metric will be

measured. Usually quantitative metrics are used to assess whether the changes in outcomes

reflect an improvement. Quality improvement methodology, such as bar graphs and pie charts,

were used to assess the effectiveness of the patient-centered communication intervention in this

scholarly project.

The third question addresses what change or changes will be made that will result in

improvements. This question was assessed in the organizational assessment and will be

discussed at greater length later in the paper. Key stakeholders have identified that implementing

a patient-centered communication model in the ED will likely result in improvements; a PDSA

cycle will be used to test the intervention.

Plan-Do-Study-Act. The second component of the MFI is testing the change in a work

setting using the PDSA cycle. The PDSA was originally developed by Walter Shewhart as the

plan-do-check-act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to

PDSA, replacing "Check" with "Study" (Deming, 1994).

The planning stage guided the design phase of this project. Planning the project is the

foundation of the entire cycle, and should not be rushed (Deming, 1994). A quick and impulsive

start may be ineffective, costly, and frustrating (Deming, 1994). Initial baseline data related to incidents of workplace violence was done in the planning phase.

The second step is "do", and is the implementation phase of the project. The patient-centered communication project was carried out on a small scale and only focused on ED nurses and patient care assistants, and security staff. During the "do" phase, problems and unexpected observations were documented (IHI, 2017). By conducting informal staff rounds and observations during this phase, modifications were done in real time.

The last two steps are "study" and "act". Step 3 is the "study" phase, which is when data will be collected and analyzed. Time was taken to reflect on what was learned and decisions were made about whether modifications needed to be made to the current project. Step 4 is the "act" phase. The team decided whether to adopt the change, abandon it, or run through the cycle again making modifications. Such modifications may include using different environmental conditions, different materials, different people, or different rules (Deming, 1994). Addressing each of the questions and testing the intervention using the PDSA cycle helped guide the planning and evaluation of the project.

Need and Feasibility Assessment

Conducting an organizational assessment prior to a new project implementation is important to ensuring sustainable success (Burke & Litwin, 1992). Assessing an organization using a validated framework helps to identify priorities that may not have been obvious initially, determine needs and analyze gaps of an organization, and achieve the mission and goals (U.S. Department of Health and Human Services Health Research and Services Administration, 2016). The purpose of the organizational assessment was to provide a clear understanding of the health care system identified for program implementation. The focus was to assess the readiness for a

patient-centered communication program that will help professionals in the ED interact safely

and more effectively with patients who have a mental illness.

The Burke-Litwin OP&C Model provided the theoretical framework for assessing a

community-based hospital (CBH). The causal model of organizational performance and change

(OP&C) is based on the premise that motivation is predictable; and motivation ultimately results

in performance (Burke & Litwin, 1992). This model accounts for external environment,

performance, and organizational culture.

The current form of the model uses arrows to describe which variables influence other

variables, and also notes differences between transactional and transformational factors in

organizational behavior and change (Burke & Litwin, 1992). Refer to Figure 5 for a diagram of

the model.
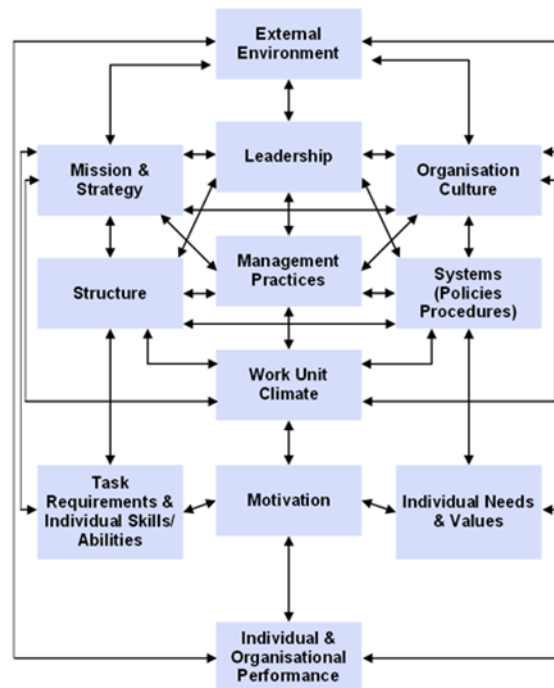
Figure 5. The causal model of organizational performance and change (Burke & Litwin, 1992).
Used with permission from Sage publishing (see Appendix F).

In the OP&C Model, the external environment box at the top represents the input or the dynamics involved in organizational performance and change, and the individual and organizational performance represents the output, or the result of change. Burke and Litwin (1992) describe the arrows connecting the two as the feedback loop. The arrows go in both directions suggesting that the organizational performance impacts the external environment and in turn is affected by the external environment (Burke & Litwin, 1992).

The objective of conducting a system level assessment was to identify readiness for changes and also sources of potential resistance to change, both affecting individual and organizational performance (Burke & Litwin, 1992). In order for successful change to occur, the top transformational boxes in the OP & C Model must be adequately assessed. Transformational leaders, in turn, influence how an organization responds to the changes, impacting organizational performance. The feedback loop has bidirectional arrows, which reflects that a change in one box in the model will have an impact on another box (Burke & Litwin, 1992). The model has multiple reciprocal relationships with all aspects being inter-related, indicating that work climate impacts and is impacted by management practices and leadership. These in turn impact and are impacted by motivation.

A Strengths-Weakness-Opportunities-Threats (SWOT) analysis was completed to assess support for improving care of patients with mental illness, specifically in the ED (Bryson, 2011). The SWOT analysis identifies real and potential strengths, weaknesses, opportunities, and threats Refer to Figure 6 for a complete SWOT analysis.

Strengths	Weaknesses	Opportunities	Threats
• Highly trained and skilled leaders	• Inconsistently trained staff and leadership in the care of patients with mental illness	• Develop more formalized succession planning	• Potential for staff and patient injury due to lack of training
• Leaders with Lean training	• Inconsistent motivation from some related to improving skills needed to care for patients with mental illness	• Continue to develop process improvement teams related to improving care for patients with mental illness	• Potential for staff and leaders to sabotage improvement work related to care of the psychiatric patient
• Leaders motivated to improve care for patients with mental illness	• Not adequate space in the ED or on medical units to care for patients needing psychiatric care	• Leaders to sponsor improvement teams related to patients with mental illness to help with change management	• Potential for elopement and increased patient agitation due to lack of therapeutic space
• Strong shared governance model	• Psychiatric patient volume increasing before training or appropriate staffing can occur in the ED	• Leverage staff nurses involvement in process improvement teams	• Potential for burnout and compassion fatigue
• High % of RNs with BSN and specialty certification	• ED staff overwhelmed with increase psychiatric volume	• Staff nurses can more formally coach and mentor colleagues in area of expertise	• Potential for patients leaving without being seen due to long wait times and staff not always therapeutic
• Robust psychiatric resources within the organization	• Lack of psychiatric prescribers in the ED	• Utilize certified psychiatric nurses or psychiatric nurse practitioners to help educate, coach, and mentor staff in the ED	• Shortage of psychiatric professionals and dissolution of Joint Venture

Figure 6. SWOT Analysis (Bryson, 2011). Used with permission by John Wiley & Sons (see Appendix G).

Some of the key strengths for the CBH were that their leaders are trained in Lean methodology, leadership is committed to improving care for patients with mental illness, and there are robust psychiatric resources within the organization. Building on the strengths, some key opportunities included the continuing development of process improvement teams related to improving care for patients with mental illness, leveraging staff nurse involvement on those teams, and utilizing the psychiatric nurses to coach and mentor colleagues, particularly in the ED as the psychiatric population increases.

One of the weaknesses and threats in the organization was that the volume of psychiatric patients was increasing quicker than the staff could be trained. Staff lacked the individual skills required for the task requirements, which had the potential to impact organizational performance (Burke & Litwin, 1992). While working closely with the ED team, a gap was identified specifically related to nurses not having enough training and education to be able to communicate effectively with patients who have a mental illness. ED employees were expected to care for patients who often times have challenging behaviors. This then led to the ED employees feeling unsafe, which likely contributed to negative outcomes for staff and patients (Good, J., personal communication, April 13, 2017).

Additionally, not all staff and leaders were interested in learning about how to more effectively care for individuals with mental illness. While many leaders were committed to the goal of improving overall care for patients with mental illness, this was not consistent organizationally. Many frontline employees lacked the motivation to develop skills and knowledge, thereby impacting individual and organizational performance. Time was needed in the planning phase of the project to help all key stakeholders understand the need for additional training required to improve safety for patients and staff.

Another significant threat was related to the external environment. There were limited psychiatric resources in the area, making it difficult to adequately staff the ED with appropriate psychiatric professionals. The potential dissolution of a key partnership with a local psychiatric organization could also impact the number of psychiatric professionals to whom CBH will have access. The lack of collaboration with community partners could potentially decrease revenue and impact organizational performance. Continued work was needed to address the need for improved collaboration.

Additionally, there was no current therapeutic space for patients who were spending hours in the ED awaiting disposition. The lack of space could have led to an increase in patient elopement and patients leaving without ever being seen. This was a systems issue, where budget development and human resource allocation did not include designing a therapeutic space in the ED. The organizational leaders were not in the position to make changes related to the limited therapeutic space in the ED, making patient-centered communication skills even more important.

Lastly, another threat was related to the work climate in the ED. As employees became overwhelmed with the increase of psychiatric volume, there was a potential for increased burnout, which could then affect relationships with patients and coworkers (Chiovitti, 2008). An unhealthy work climate can lead to poor organizational performance (Burke & Litwin, 1992). Providing ED staff with additional tools related to effective communication may improve staff experience by decreasing incidents of workplace violence (Angland, Dowling, & Casey, 2014; Gillespie et al., 2014).

After an assessment of strengths, weaknesses, opportunities, and threats, communicating with patients with mental illness in a competent manner had been identified as a need, especially when assessing the flow of patients through the emergency department. While there were certainly many challenges that could have impacted attempts to improve care for patients with mental illness, the initiative was strongly supported by influential leaders in the organization. There was a sense of urgency and a guiding team. The strengths and opportunities were significant enough for successful implementation of an evidence-based patient-centered communication model designed to improve staff perception of safety in the workplace .

Project Plan

In the preceding sections, the impact of an increasing number of patients accessing the ED with primary psychiatric complaints and the concerning problem of lack of education and training was discussed. The goal of this project was to implement an evidence-based patient-centered communication training program in the ED for the nursing, nursing assistant, and security staff. The methods used for the design, implementation, and evaluation of the evidence-based scholarly project are presented in the following sections.

Purpose of Project with Objectives

The purpose of this scholarly project was to design patient-centered communication education for ED and Security staff that would focus on developing sophisticated communication skills, allowing them to provide patients with emotional support and involve patients in their treatment. The literature supports the use of communication education in order to significantly increase the likelihood that health care providers exhibit patient-centered communication skills. All ED nurses, nursing assistants, and security officers were expected to attend. Critical to successful implementation, goals and objectives of the education were clearly communicated to all who attended.

As discussed previously, ED nurses report exposure to physical or verbal abuse (ENA, 2011), and most feel they lack tools and skills to handle communication well (Loeb et al., 2012). A pre and post-test, which focused on nine key points, was given to all participants, and was used to evaluate learning (see Appendices H and I). One of the objectives was to increase knowledge and understanding about how to effectively communicate with patients with a mental illness as evidenced by an increase in test scores by at least 30% (Alliger & Horowicz, 1989).

Another project objective was that staff would find the education valuable and be able to use the tools in everyday practice. The DNP student conducted a formal post-intervention survey using SurveyMonkey© and informal interviews with the staff to assess whether this objective was met (Appendix J). The interviews were succinct and included three questions related to using patient-centered communication with patients who have a mental illness. No names were attached to the comments to maintain confidentiality.

Type of Project

This scholarly project was considered a quality improvement project. An evidence-based patient-centered communication intervention was implemented in an educational format. Metrics were collected prior to the education and after to assess whether a change occurred related to perception of workplace safety. Quality improvement methodology, such as tables and bar graphs, were used to analyze data.

Setting and Needed Resources

The project took place at a community-based hospital (CBH) located in West Michigan. There was a positive culture at the project site; however, creating a guiding team was essential to ensuring a successful change implementation (Kotter, 1996; IHI, 2017). In addition to several frontline nurses, key members of the ED leadership, which included the Director, Manager, Clinical Nurse Leader (CNL), Educator, and Clinical Nurse Specialist (CNS), were vital members of the team. This team will be important to the sustainability of the project outcomes as they have position power, expertise, credibility, and leadership skills. No one individual was able to develop the right vision, communicate the vision to a large number of people, eliminate key barriers, and hardwire the change in the unit culture. A guiding team was required to ensure the success of the project.

The ED leaders provided a strong guiding coalition as they had direct knowledge about the culture of the unit and were also able to lend credibility to the project. Frontline staff volunteers were recruited to help serve as actors in recorded vignettes to be used during the discussion portion of the training. This helped to gain buy in from the ED staff receiving the education. The ED director provided mentorship and executive sponsorship for the project. Additionally, the video specialist employed by the hospital provided assistance in developing the recorded content of the education.

Design for the Evidence-Based Initiative

The DNP student developed patient-centered communication education using a PowerPoint format (Appendix P). The education was reviewed by the guiding team for ease of understanding.   The education was designed using the X4H framework and implemented using the MFI framework. The education was conducted in a classroom format lasting two hours. Several educational sessions were offered to provide scheduling flexibility for the staff. Staff was expected to register and attend one educational session.

Using volunteer actors from the ED team, the DNP student delivered patient-centered information which included three vignettes. The vignettes addressed a common ED scenario and were taped in advance using a video specialist employed by the hospital. Each vignette demonstrated an effective and ineffective way to communicate in a patient-centered manner. The vignettes were presented at each educational session with discussion to follow. Increasing involvement of key ED staff from the beginning was consistent with creating a guiding team, which was essential to successful change implementation (Kotter, 1996; IHI, 2017).

Discussion with the group was a key component to investigate barriers for successful implementation and was modified throughout with each session depending on the needs of the

group. Initially, time was spent on role playing. This was modified slightly to address some of

the barriers that were expressed by the participants. The DNP student discovered what staff

perceived to be barriers preventing them from providing therapeutic care and addressed their

concerns in real time. Aligning systems within the department to the patient-centered vision will

be imperative to sustainability.

Participants and Recruitment Strategies

The ED and Security managers sent an informational email to all staff. The email

included information about the purpose of the education. Informational postings in the break

room and shift huddles were also used to communicate the expectation of attending one patient-

centered educational session. The DNP student sent an additional email asking for volunteer

actors to participate in the taping of the vignettes. The ED leadership team (Clinical Nurse

Leader, Educator, and Clinical Nurse Specialist) attended at least one session and helped

facilitate the education and discussion.

Measurement: Sources of Data and Tools

Pre and post-test. The DNP student administered a pre and post- test to quantify the

knowledge attained in the class from a group of participants with diverse learning styles and

educational backgrounds (Appendix H and I). The pre and post-tests were used to assess the

ability of the participants to retain and recall facts about the educational content. The tests were

given immediately before and after each session.

The pre-test consisted of nine questions designed to assess knowledge attained; each

question was worth one point for a total of nine points. The pre-test also included demographic

questions as well as questions about: (a) how often the participant experienced workplace

violence, and (b) the confidence level of each participant related to communicating with

individuals with a mental illness (Appendix H). The post-test included questions from the pre-

test, excluding demographic questions (Appendix I). Informal anecdotal information was

collected while making formative evaluation rounds during implementation phase. Staff

comments were collected and shared with the leadership team. The primary outcome metric was

the perception of workplace safety pre and post-education.

       Post-intervention survey. The DNP student sent an email to all of the participants

following the last educational session with key learning points from the education (Appendix Q).

A post-intervention survey was sent two weeks following the educational sessions via Survey

Monkey (Appendix J). The survey was succinct and consisted of three rating questions: (a) to

what extent did you find value in the patient-centered communication education, (b) to what

extent have you been able to use the patient-centered communication tools in your practice, and

(c) to what extent have you experienced an improved perception of workplace safety since

receiving the education. Additionally one open-ended question was included: What barriers

prevent you from using patient-centered communication? The survey allowed the DNP student to

assess the overall value of the patient-centered education and whether the participants

experienced an improved perception of workplace safety (Appendix J).

       Informal Rounding. The DNP student also conducted informal rounds asking staff if

they have had a chance to use any of the patient-centered communication training in their daily

work, and whether they had additional questions. The rounding was conducted to collect

qualitative data in an effort to assess whether staff felt that the education was helpful in

improving their ability to communicate with patients who have a mental illness and what

perceived barriers still exist in using the patient-centered communication tools.

Steps for Implementation of Project

Refer to Figure 5 for sequential steps, including timelines, in implementing the project.

The implementation phase began with the DNP student submitting an application to the affiliated

university's human research review committee as well as the institutional review board affiliated

with the CBH. The implementation phase ended when all post intervention data was analyzed.

Phase 1 Design	Intervention/Task	Timeline
	Approval from IRBs	July 17, 2017
	Form Completion	August 1, 2017
	Obtaining approval from the Doctorate of Nursing Practice project team	August 1, 2017
	Initial meeting with ED team	August 8, 2017
	Email sent to recruit actors for vignettes	August 11, 2017
	Design review meeting with ED team	August 18, 2017
	Video recording of vignettes	August 29, 2017
Phase 2 Implement and Analyze Data	Intervention/Task	Timeline
	Conduct Educational Session/Pre and Post-test	September 11, 2017
	Conduct Educational Session/Pre and Post-test	September 25, 2017
	Conduct Educational Session/Pre and Post-test	September 26, 2017
	Conduct Educational Session/Pre and Post-test	September 27, 2017
	Conduct Educational Session/Pre and Post-test	September 28, 2017
	Email sent to participants with summary of education	September 29, 2017
	Begin informal rounding	September 29, 2017
	Met with ED leadership team to design post-education survey and provide feedback about educational sessions	October 9, 2017
	Post-education survey sent via Survey Monkey link in an email	October 11, 2017
	Survey closed. Data analyzed	October 25, 2017

Figure 7. Project Design and Implementation Phase

Project Evaluation Plan

Descriptive statistics and quality improvement methodology were used to evaluate this project. As mentioned earlier, a pre and post-test were administered to all participants attending the education. The post-test mean score helped to assess the extent of the participants' learning of the content.

The DNP student compared the mean pre and post-test scores. The test questions focused on the educational content and the confidence level of the staff related to communicating with patients who have a mental illness. There were a total of 83 participants (N=83). The data was collected and displayed by the DNP student using bar graphs to display the difference in mean scores and post-intervention data. Tables were used to describe the sample and to aggregate qualitative data into themes.

The results of the project intervention include a general description of the participants, mean scores of the pre and post-tests, and post-intervention data. Post-intervention data included survey results and qualitative data.

Participant Demographics. A total of 83 nurses, nursing assistants, and security officers took part in the project. The nurses and nursing assistants worked in the ED, and the security officers, while not assigned solely to the ED, often assisted in the department. This group of participants were 65% nurses (n=54), 18% nursing assistants (n=15), 16% security officers (n=13), and 1% other (n=1) (Table 1).

Table 1

Role of Participants

Role	n	%
Nurses	54	65
Nursing Assistants	18	18
Security Officers	13	16
Other	1	1

This was a relatively young group with most participants between 18 and 29 years of age (Table 2). There were no participants over the age of 59 years. Years of experience ranged from 0.5 to 30 years, with a mean of 5.1 years (Table 3).

Table 2

Age Range of Participants

Age Range	n	%
18-29	43	52
30-39	27	33
40-49	9	11
50-59	3	4

Table 3

Years of Experience

Range	Mean
0.5-30	5.1

Pre and Post-Test Scores. The mean pre-test score was 5.4 with a range from 3 to 9. The mean post-test score was 8.2 with a range from 4 to 9 (Figure 9). The post-test scores increased by 34% as compared to the pre-test, meeting the objective of improving by at least 30% (t=4.23, p<0.05).
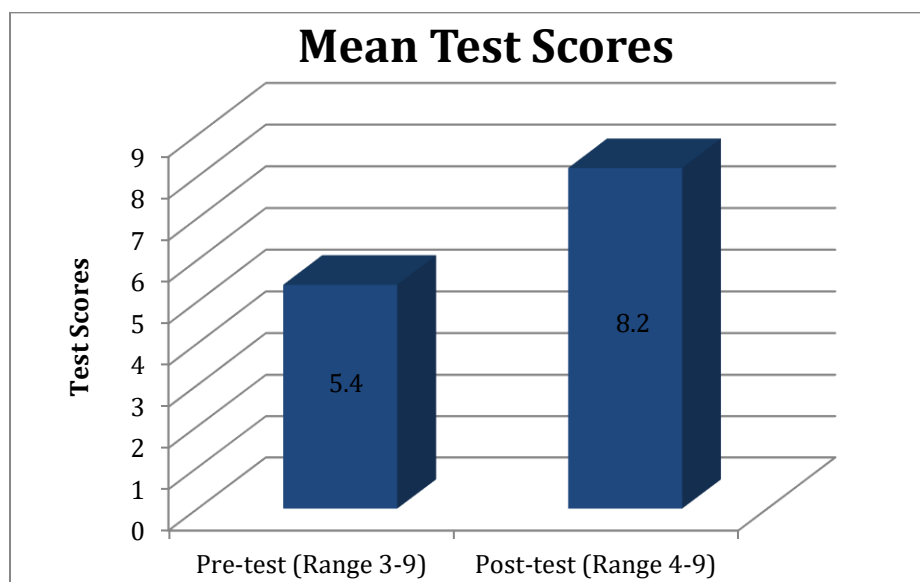
Mean Test Scores

Figure 8. Mean test scores.

Post-Intervention Survey Results. Approximately 27% of participants (n=22) responded to the post-intervention survey. Refer to Appendix K for complete detail of the survey. The survey was sent via SurveyMonkey© in an email link. When asked to what extent the participants found value in the patient-centered communication education 4% (n=1) answered no value, 4% (n=1) answered a little, 38% (n=8) answered some, 50% (n=11) answered quite a lot, and 4% (n=1) answered a great deal (Figure 10). Almost all of the participants, 90.48% (n=19) found at least some value to the education. Given that the team did not initially welcome additional education this value is particularly impressive.

To What Extent Did you Find Value
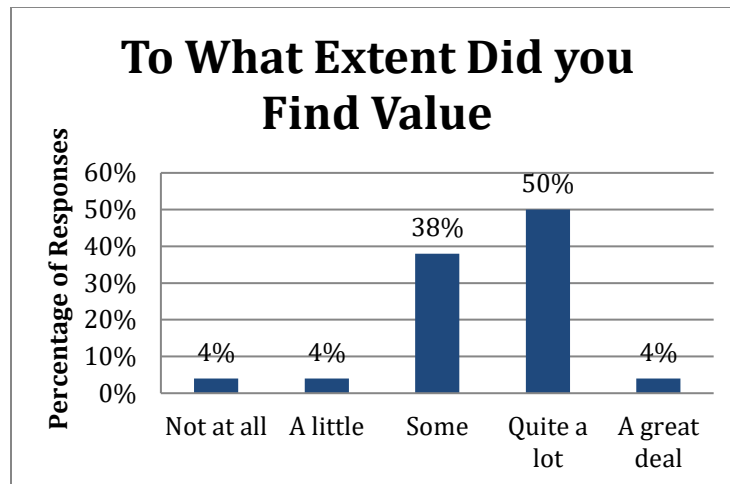
Figure 9. Value in patient-centered education by percentage of responses

Participants were also asked if they had been able to use the patient-centered communication tools in their practice. When asked to what extent they had been able to use the tools presented in the patient-centered communication education 0% (n=0) answered not at all, 27 % (n=6) answered a little, 50% (n=11) answered some, 23% (n=5) answered quite a lot, and 0% (n=0) answered a great deal (Figure 11). All of the participants, 100% (n=21), were able to use the tools in practice at least a little. Receiving education and then immediately incorporating the learnings into practice may increase sustainability.

To What Extent Have You Been Able to Use the Tools
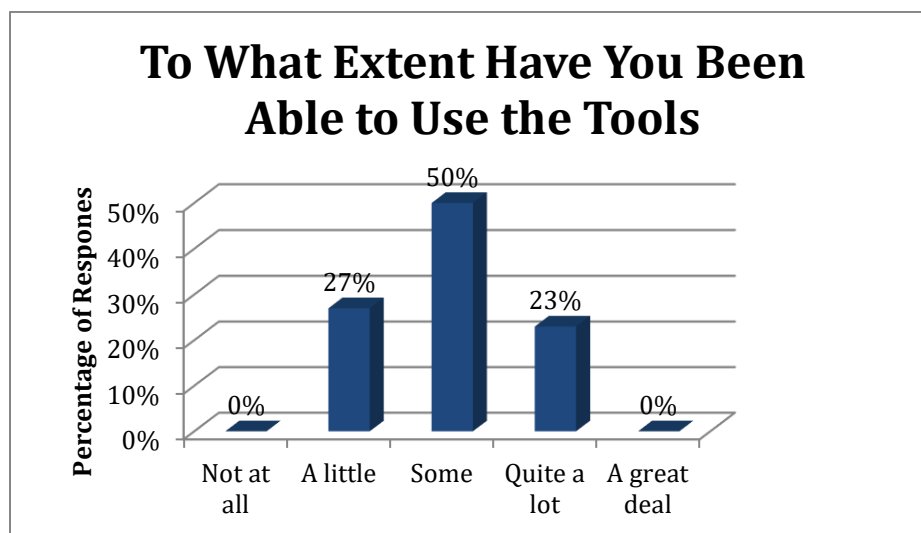
Figure 10. Use in Daily Practice by percentage of responses

Lastly, participants were asked if they felt that they had experienced an improved

perception of workplace safety since receiving the education. When asked to what extent they

had experienced an improved perception of workplace safety, 14% (n=3) answered not at all,

18% (n=4) answered a little, 36% (n=8) answered some, 18% (n=4) answered quite a lot, and

14% (n=3) answered a great deal (Figure 12). The majority of participants, 68% (n=15)

experienced at least some improved perception of workplace safety. More time is needed to

determine whether the education intervention has a long term effect in the perception of

workplace safety.

Figure 11. Change in Perception of Workplace Safety by percentage of responses

Qualitative Data. Some participants interviewed reported positive feedback but many

also noted barriers that prevent them from always communicating in a patient-centered manner.

Refer to Figure 12 for a list of participant comments and a theme breakdown. Barriers include

patient behaviors (30%), not having enough time (25%), and department culture (20%). There

were also positive comments made (25%) stating that there were no barriers to using the tools in

practice.

Themes related to Barriers to using Patient-Centered Approach	Comments
Patient Behaviors (30%)	Difficult to implement if patient is already agitated.
	Some of the patient population prohibits this approach.
	No barriers from the tools, but sometimes patient behaviors become the barrier.
	Patients don't always want to listen.
	Patients that will listen
	For security, we are called after the tools have failed.
Time (25%)	Workflow, pace of the department
	Three comments made related to time being a barrier for always using patient-centered communication.
	Sometimes there is not enough time to focus and we are not able to spend the time that we want with the patients.
Department Culture (20%)	I would like to be able to give my colleagues feedback about interactions that may have been better handled differently. I don't always feel safe enough to do that. We work in a pretty hostile work environment, and it's not always the patients.
	No one wants to be viewed as weak, and no one wants to stop and take time to report things. However, I see the value and importance of reporting and keeping the environment safe.
	It seems like we are afraid that we will be written up sometimes if we don't follow the rules, specifically related to suicidal patients not wanting to get into a gown.
	We don't debrief enough after workplace violence stuff. We should do that more.
No Barriers—Positive (25%)	I was able to use what I learned to talk a patient into staying with us to complete a work up. In the past, I would have called security to help prevent her from leaving. In this case, I was able to talk with her and she stayed voluntarily.
	I have thought about what you said related to 'only say what you'd be proud to have quoted back to you the next day, by your boss' and have heard other staff reminding each other. That seemed to resonate with us.
	Three comments made about no barriers to using the patient-centered communication tools in daily practice.

Figure 12. Comments Regarding Patient-Centered Communication

Ethics and Human Subjects Protection

This project received ethical consideration by the Grand Valley State University Research and Review Board. The project also required consideration by the CBH Research and Review Boards. The Boards determined that the project was not research, but a quality improvement project (Appendix K & L).

Budget

Providing education and training for ED and Security staff resulted in time, commitment, and additional costs. An estimated two hours of training for 83 staff with an average salary of $35/hour resulted in $5810. The cost was charged to the ED and Security cost centers. Additionally, meeting with the ED leaders in the design, implementation, and evaluation phases resulted in additional time and commitment, resulting in opportunity costs. Cost of using a video specialist to record and edit the vignettes role-playing also resulted in additional opportunity costs.

Stakeholder Support/Sustainability

When considering implementing interventions to improve care for individuals with mental illness accessing the ED, there were many internal and external key stakeholders. Refer to Figure 6 for a visual representation of stakeholder identification.

External Stakeholders

Community Mental Health Organizations

Law Enforcement

Donors

Internal Stakeholders

ED staff — Patients/families with and without mental illness

Individuals with Mental Illness

Other Psychiatric Hospitals

Executive Team — Physician Partners

Local Community

Board of Directors — National Health System

Regulatory Agencies

Community partners/payers

Figure 13. Key Stakeholders (Bryson, 2011). Used with permission by John Wiley & Sons (refer to Appendix M).

A stakeholder analysis was useful in providing information about the internal and external politics facing the organization. A power versus interest grid helped to determine which stakeholders must be taken into account in order to implement an improvement strategy successfully (Bryson, 2011). Not all stakeholders had the same level of authority in the organization or the same interest in the process improvement initiative. The power versus interest grid helped assess which stakeholders would be most relevant when implementing or presenting a proposal for the change. Refer to Figure 7 for a visual representation of a power versus interest grid.
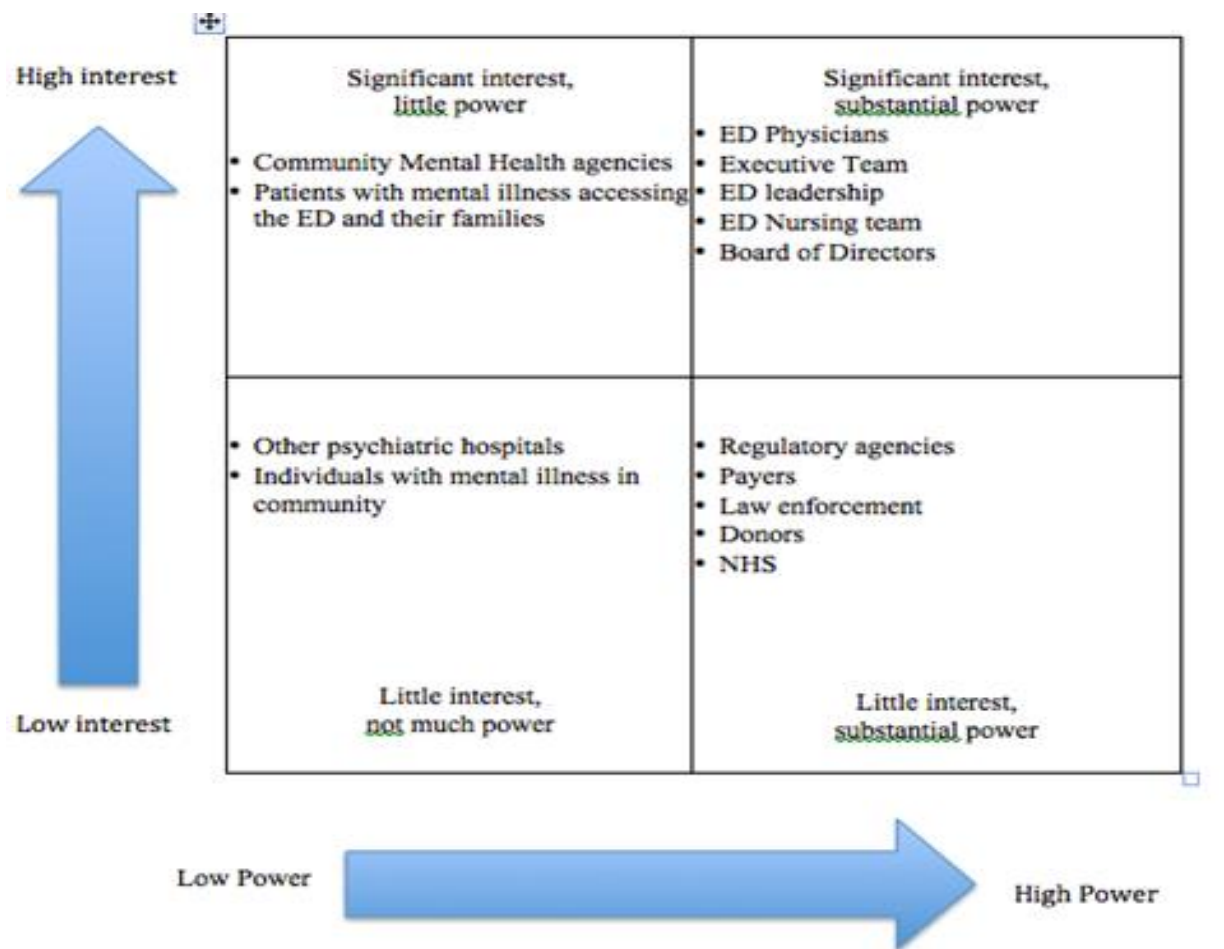
Figure 14. Key stakeholder power versus interest grid (Bryson, 2011). Used with permission by John Wiley & Sons (refer to Appendix N).

In the CBH, community mental health agencies had significant interest in the psychiatric care delivered in the ED; however, they had very little power regarding change implementation. Conversely, payers had lower interest currently in how the care is delivered for psychiatric patients in the ED but had significant power to influence a timely discharge plan.

The ED leadership team and the senior executives at the CBH understood the current educational need. A risk consultant had also recommended that the ED staff receive additional training on how to more effectively care for patients with a mental illness. The frontline staff was currently engaged in many quality improvement teams, including a team to address the care of

patients with mental illness. This team was interdisciplinary and open to learning about new

approaches to improve safety for patients and staff. Additionally, the ED director had provided a

letter indicating support for this project (Appendix O).

      The format of the education will allow for an easy upload of the information to the

electronic educational system. Given that the project intervention resulted in an improvement in

outcomes for staff perception of workplace safety, a plan for dissemination to the rest of the

frontline staff throughout the organization is recommended. Celebrating small successes should

also be included in the dissemination plan, as this is a key component in maintaining leadership

involvement and staff engagement.

      Providing frontline staff with feedback related to the outcomes of the project was

important for sustainability. Celebrating small successes helps justify that the sacrifices and

changes that were made in their practice were worth it (Kotter, 1996). Additionally, unit

champions and frontline staff directly involved in the development of the educational format

should receive positive feedback from ED leadership in order to further build morale and

motivation. All of the above elements will be necessary for continued sustainability of the initial

change in outcomes.

Implications for Practice

      Communication strategies promoted in the existing literature point to a patient-centered

approach. While the participants stated that they found value in the education and most were

able to translate the leaning into practice, there were legitimate perceived barriers to full

implementation. Barriers will need to be addressed to maintain staff buy-in.

      One barrier that participants noted during post-education discussion was unit culture.

Many felt that they would like to debrief with colleagues after an occurrence of workplace

violence and were unable, due to time constraints or feeling that they would get a negative

response. Several participants commented that they did not feel safe enough to communicate

directly or share feedback with each other. This information was shared with the ED leadership

team, who will be using this information to guide further projects related to improving the

culture of safety on the unit.

Patient-centered communication has been associated with improved patient outcomes,

such as overall patient satisfaction (Zolnierek & Dimatteo, 2009; Griffin et al., 2004).

Additionally, patient-centered communication, particularly when used with patients with a

mental illness, has been associated with increased staff comfort (Kemp et al., 2009). The

timeline of this project did not allow for adequate examination of patient and staff outcomes.

Further monitoring of patient experience data, rate of restraint use, and occurrences of workplace

violence will be required to determine additional impact of the project intervention.

Additional innovative approaches will be required to ensure a safe environment for

patients and nurses. This project intervention is an example of one such intervention; however,

further replication will be necessary to test for quality improvement. Regular on-going

supervision will also be necessary to sustain the gains in the longer term.

Project Strengths/Successes

A major strength of this project was that the intervention was designed to improve

outcomes for patients and staff. Often staff receives education focused on improving patient

outcomes without considering the impact on their work environment. Of course, patients should

be able to count on receiving care that meets their needs. Improving patient experience, however,

must not come at the expense of staff experience. The strength of this project was that there was

an appropriate balance between staff and patient focus.

Another strength of this project was involving frontline staff in the design phase. Taking

the time to convey a sense of urgency, establishing a guiding collation, and determining clear

objectives was essential in gaining buy-in. Key members of the ED team were recruited to act in

the recorded vignettes. The vignettes were portrayed in a way that provided a balance of humor

and reality when discussing challenging patient/staff interactions. Staff referenced the scenarios

for weeks after the educational sessions, which helped them retain the new knowledge.

The time spent establishing relationships with the participants and understanding their

ED work environment was important to the success of the project. Educators often miss the

importance of understanding the work environment and experiences of the frontline staff.

Education is provided without taking the time to assess the environment and get participants to

understand that there is a reason to make changes in practice; there is sense of urgency to make

the change. The DNP student was able to take the time to establish a sense of urgency and gain

buy-in from the ED leadership and frontline team.

Another unexpected success and strength of the project was that the frontline staff started

to open up about needing and wanting a culture change in the ED. This was most likely due to

the time spent establishing relationships. Historically, this team has been proud, passionately

defending their culture, a culture where they either did not need to debrief about occurrences of

workplace violence or that they did not have time to do so. This project led to conversations

among the team about changes they want to consider making.

At each of the educational sessions, at least one of the participants mentioned that the

team may want to start talking more about occurrences of workplace violence, and that they

could help each other connect better with patients. This then led to how they accept and give feedback from and to each other. The DNP student was able to facilitate conversation about safety on the unit, psychological and physical safety. The DNP student was able to meet with the ED leadership team to communicate themes from the educational sessions. The leadership team has committed to facilitating more sessions related to unit culture.

Project Weaknesses/Difficulties

One of the weaknesses and difficulties encountered during the evaluation phase of the project was that many of the participants felt that incorporating patient-centered communication tools into their practice resulted in more time, which they did not feel they had. This had been a theme at the start when conducting a unit assessment. The frontline staff felt that they needed additional training to help them communicate with patients who may be exhibiting challenging behaviors, yet they did not feel they have time to operationalize the concepts from the training. A follow-up project focusing on addressing some of the perceived barriers would be helpful.

Another weakness was the timeline of the evaluation phase of the project. Patient-centered communication has been associated with improved outcomes, such as overall patient experience and decreased frustration (Zolnierek & Dimatteo, 2009; Griffin et al., 2004). The evaluation phase did not allow for enough time to collect and analyze metrics reflecting the full project impact.

Another weakness and difficulty was finding an appropriate balance between managing risk related to patients with mental illness and managing patient-centered care. The organization had recently hired a consultant to focus on areas of risk in the ED. The issue of risk and patient-centeredness, however, is a polarity to be managed as opposed to a problem to be solved (Johnson, 2014). The ED team struggles with implementing standards for managing risk and

allowing the flexibility for a patient-centered approach. Staff commented about not feeling that they could be flexible related to patients with suicidal ideation. More work is needed in order to capitalize on the inherent tension between the two sides, allowing for a both/and approach to this polarity.

Reflection on DNP Essentials

The nurse executive competencies (American Organization of Nurse Executive [AONE], 2015) and eight essential doctor of nursing practice competencies (American Association of Colleges of Nursing [AACN], 2006) were the foundation for the scholarly project. In alignment with DNP Essential I, *Scientific underpinnings for practice*, the patient-centered communication model in the ED was implemented to improve the perception of safety felt by the unit staff. Use of an evidenced-based framework was integral in laying the foundation for the project.

Components of DNP Essential II, *Organizational and systems leadership for quality improvement and systems thinking* (AACN, 2006), and the AONE competencies related to *leadership and communication* were used throughout the scholarly project. For instance, advanced communication skills were utilized when collaborating with the ED interprofessional leadership team during the planning and implementation phase of the project. Additionally, a comprehensive organizational assessment, utilizing a conceptual framework, also aligned with systems thinking.

The literature was appraised at the beginning of the project to confirm the benefits of the proposed intervention, and to identify an appropriate mode of implementation. Additionally, a key component of the clinical immersion was creating standard treatment guidelines for the care of the individual with mental illness in the ED. These practice initiatives demonstrate

competency in DNP Essential III, *Clinical scholarship and analytical methods* and the AONE

competency of *clinical practice knowledge* (AONE, 2015).

The project intervention consisted of education provided in a PowerPoint format with

video recorded vignettes embedded. DNP graduates are expected to use information technology

to support and improve patient care and health care systems. This portion of the project

intervention demonstrates competency in DNP Essential IV, *Information systems/technology and*

patient care technology for the improvement and transformation of health care (AACN, 2006).

In regards to DNP Essential V, *Health care policy for advocacy in health care* (AACN,

2006), the outcomes from this project will influence health care policy at the community

hospital, and potentially the health care system of which the community hospital is a member.

The problem of workplace safety and occurrences of WPV, especially in EDs has been widely

documented (Harrell, 2011; ENA, 2008). The design of interventions, such as the one

implemented in the project, are influenced by health care policies that frame health care safety,

however, outcomes from this intervention can be used to influence the development of other

safety related policies.

Throughout the project, there was significant amount of interprofessional collaboration

with a focus on improving patient health outcomes at the unit and population level. Gaining buy

in from the ED team and establishing a clear sense of urgency about the problem required time

and sophisticated communication skills. Participating on an ED team, which included physicians,

nurses in several different areas of specialty, social workers, and members of the security team

allowed for demonstration of competency in DNP Essential VI, *Interprofessional collaboration*

for improving patient and population health outcomes (AACN, 2006) and the AONE

competency of *communication* (AONE, 2015).

Plans for Dissemination of Outcomes

Information from the organizational assessment revealed that the CBH executive team was ready to make changes related to the care of patients with mental illness, particularly those patients accessing the ED. As identified in the preceding sections, key stakeholders recognized problems with increasing WPV against nurses and were invested in implementing interventions to improve care for patients with a mental illness.

Based on information gleaned from the organizational assessment, improved patient-centered communication skills was an area of opportunity throughout the organization. Given the heightened awareness related to WPV, and the positive outcomes from the patient-centered communication education in the ED, the recommended next step will be to implement the education throughout the larger organization. Plans will be formalized with the organizational leadership to educate current employees and then incorporate the educational module into new-employee orientation.

Successful interactions between patients and nurses lie at the heart of nursing. To advance knowledge further, the communication education should be replicated using a PDSA approach, making modifications when necessary to increase applicability in unit specific settings. Only in this way will the care for patients and nurses advance beyond a series of fragmented initiatives focused only on marginal cost reductions and improvements.

The DNP student will present an executive summary to the Chief Nursing Officer and other key leaders. The specifics and next steps of a sustainability plan will then be determined with input and collaboration from the leadership team. A copy of the scholarly project will be provided to the hospital site, which will include the electronic educational content, including the vignettes. A copy will also be uploaded to Grand Valley State University's ScholarWorks and a

poster presentation has been done at the American Nurse Association Conference sharing

preliminary results.

Conclusion

A group of nurses, nursing assistants, and security officers took part in a project to

enhance their communication skills. The goal of the project was to ultimately improve the

perception of workplace safety. They were able to reflect more deeply on their relationships with

patients and adopt principles of patient-centered communication into their everyday interactions

with patients.

Fifteen years have passed since an IOM report documented the inadequacy of care for

individuals with serious mental illness (IOM, 2001). The CBH leadership acknowledged this

problem and the significant numbers of individuals with mental illness accessing the ED. A

sense of urgency had been established for the implementation of a patient-centered

communication model in the ED and for improving workplace safety.

Project implementation was successful in providing education to ED and Security staff so

that they were able to utilize patient-centered communication tools and connect more effectively

and safely with patients who had a mental illness. The timing for implementation was ideal;

nurses felt unsafe in the workplace, which was simply unacceptable. Participants felt that the

education was valuable. They acknowledged that they were able to use the tools in their

everyday practice. Additionally, providing patient-centered communication education to all ED

and security staff led to an improved staff perception of workplace safety.

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Appendix A

Literature Synthesis Table

Author	Year	Number of participants	Study Design	Evidence Hierarchy	Intervention	Findings	Limitations	Statistics
Cleary et al.	2012	23 papers reviewed	Meta-synthesis of qualitative studies	Level 1	Assessed and analyzed research related to nurse-patient interaction	28 themes in 6 categories reflected positive nurse-patient interactions; sophisticated communication, subtle discriminations, managing security parameters, ordinary communication, reliance on colleagues, personal characteristics important to patients. Subthemes and explanations within each category.	All studies involved nurses working in inpatient psychiatric units and not emergency departments. Some themes draw on evidence from few studies with small samples, so limiting the general translation to other settings.	Critical Appraisal Skills Programme (CASP) to assess and analyze qualitative studies
Cousin et al.	2012	167	Randomized Controlled Trial	Level 2	Virtual interaction with a physician	The impact of physician's caring on participant's	This study tested physician caring and sharing	Hierarchal regression analysis to test

					displaying either communicated in a low or high caring way, and either in a high or low sharing way. Caring contained expressions of concern, laughing and joking, empathy, and reassurance. Sharing communication included open-ended questions, asking for participant's opinions, asking for participants' permission, partnership statements, and shared-decision-making.	satisfaction depends on participant's attitudes towards caring. The same is true related to the impact of physician's sharing. Regardless of their attitudes, participants were generally more satisfied with physician's who had a high-caring communication style. Satisfaction with high sharing physicians depended on attitude about sharing.	communication style. It is not clear if the results would be generalizable to other professions, such as nursing.	whether the impact of the physician's caring and sharing on participant's satisfaction differed

Dwamena et al.	2012	43 RCTs, physicians and nurses	Systematic Review	Level 1	Focusing on person instead of disease, shared decision making,	Communication training was successful, shorter training was just as effective as longer training. Impact on patient satisfaction and health outcomes is mixed. Outcome measures were patient satisfaction, health behaviors, health status, and consultation process	Potential for publication bias, selection bias (due to so many studies excluded), multiplicity of outcomes led to unclear pattern of patient centeredness,	Standardized mean differences and relative risks applying a fixed-effect model, Chi-square tests,
Griffin et al.	2004	35 RCTs	Systematic Review	Level 1	Interactions between providers and patients that alter patient outcomes	Trial evidence suggests that a range of interventions can change approaches to interaction between provider and patient, some positively impact patient's health	Search strategy was limited to 3 databases, data were extracted and interpreted without any reference to original author, so may have led to underestimation of trial quality	Developed taxonomies of the interventions and outcomes using the Delphi method
Hall et al.	2014	71 physicians,	Randomized Controlled Trial	Level 2	Physician-patient interactions	In the emergency setting, female physicians	Unbalanced number of patients across settings,	Roter Interaction Coding System

		497 patients			were videotaped and analyzed for patient-centeredness	displayed more patient-centered behaviors and female physicians earned significantly higher patient satisfaction scores	and patient characteristics differed from setting to setting, generalizability of findings were limited due to study conducted in one setting in one geographic location	and Four Habits Coding Scheme was used to rate patient-centeredness. Patient satisfaction was assessed using the Consumer Assessment of Healthcare Providers and Systems survey
Haron et al.	2014	72 patients	Prospective controlled trial, cross-sectional, mixed methods	Level 3	Survey and one one-on-one interview about expectations patients with mental illness have regarding how their doctors and nurses should behave towards them.	Patients expect staff to treat them with respect and as people and not merely cases of illnesses. Patients expect to be involved in decision making about their treatment, including being informed of reports and records referring to them, and patients expect that all hospital staff, especially nurses, provide	The survey did not address how satisfied patients were with current treatment, so were unable to evaluate the impact of unfulfilled expectations. The researchers used a brief checklist to identify expectations. Because of a cross-sectional study, only associations could be demonstrated and not causality.	Expectations of nurses/doctors as frequencies, differences in frequencies and means were tested by Chi-square and two-tailed t-tests. Correlations measured by Pearson and Spearman coefficients. Qualitative data analyzed by key dimensions and divided into content themes.

						them with emotional support.		
Helitzer et al.	2010	30 physicians	Randomized controlled trial	Level 2	Communication skills training-full day training, individualized feedback on video taped interactions with simulated patients, and optional workshops to reinforce strategies for engaging the patient.	Provider training was efficacious at improving patient-centered communication and at increasing provider communication proficiencies. Effect sizes for both of the results were large. The effectiveness of the training assessed patient-centered communication and discussion of adverse childhood events both before and after the intervention. There were large and significant differences noted between the intervention and control group.	It is difficult to blind participating (in this case, providers) to their group assignment, so it is challenging to determine a casual relationship between the intervention and the results. The control group was not given a placebo or a different training topic. Another limitation is that participation in the training was voluntary. Of the 60 eligible providers, 30 agreed to participate. Those who agreed to participate were most likely more motivated to improve	Roter Interaction Analysis System and 21 communication proficiencies were used to evaluate the efficacy and effectiveness

							communication style, so may not represent the general population. Generalizability of findings may therefore be challenging.	
Kemp et al.	2009	13	Evidenced-based practice implementation	Level 6	One full day training weekly times 6 weeks with ongoing practice supervision and support between sessions. Main components of the training were therapeutic skills teaching, reflective diary, and practice tasks.	Participants expressed high levels of satisfaction with the teaching style of the program. They specifically liked the role-play activities, the weekly reflection sessions, follow-up support between sessions, and the team approach to skills development. Participants noted Improved therapeutic communication skills.	Small sample size so unsure about generalizability of results. No statistical analysis was done, so the validity and reliability of the study is questionable.	No statistical analysis done.

Maatouk-Burmann et al.	2015	42 physicians, 410 patients	Randomized Controlled Trial	Level 2	3-day structured communication skills training, using the WEMS (waiting, echoing, mirroring, and summarizing) to enhance listening skills and the NURSE model (naming, understanding, respecting, supporting, and exploring) to foster empathic verbal skills.	For data collection, patients were recruited to either the intervention or the control group. Findings support that a structured communication skills training can improve the communication behavior of physicians toward a patient-centered approach. Data were collected immediately post training and 3 months post training. Post training, patient-centered communication increased, while length of time spent with patients did not.	All patients were selected by participating physicians, which could result in selection bias. No medical outcomes data were collected. Researchers only used five workplace-based video-recordings, which could have diminished the reliability of the assessment of patient-centeredness. A difference between patient-centeredness was displayed at baseline, so the randomization procedure did not sufficiently control for confounding variables.	For analysis of communication, the Roter Interaction Analysis System and Conversation characteristics were used when coding 272 videotaped physician-patient conversations. Descriptive statistics were used to describe sample characteristics and the researchers used a small to medium effect size when measuring whether the intervention represented significant improvement in patient-centered communication.

Mikesell et al., 2016	2016	50	Qualitative study	Level 5	Semi-structured interviews and focus groups	Themes: 1) Client-centered priorities, clients and clinicians agreed on the value of autonomy and empowerment; 2) Communication and information exchange, participants expressed support for transparent communication; 3) Epistemic expertise, valuing each other's expertise, although sometimes the feeling is that clinicians do not value client's expertise about their own symptoms or how medications work for them. Communication and participant's role in decision-	Participants were from one geographical area and focused only on psychiatric medications, so unsure about the ability to translate the results.	Inductive approach to thematic analysis

						making is dynamic.		
Newman, et al.	2015	34 papers reviewed	Integrative Literature review, Qualitative-meta synthesis (13 studies), 12 quantitative studies (including RCTs), 6 mixed methods, and 3 reviews of literature	Level 1	Review studies to identify how service users experience mental health services	3 themes emerged from the literature review: 1) acknowledging a mental health problem and seeking help, stigma was identified as an issue, issues in the ED were the environment and the lack of knowledge staff had regarding mental health issues, many felt that staff in the ED did not listen to them; 2) building relationships, important components include feeling valued, feeling supported, being informed about treatment, having choices, feeling listened to, and	Many of the studies reviewed were conducted in the United Kingdom and Ireland, which may affect the generalizability of the findings.	Thematic analysis, analysis was reviewed with the co-authors and supervisors of the review. Quality of the studies were appraised using the Critical Appraisal Skills Programmes Checklists

						having trust for providers; 3) working towards continuity of care, difficulty navigating services, which leads to feelings of loneliness, isolation, and a sense of vulnerability.		
Passalacqua & Harwood	2012	26 caregivers	Controlled cohort study quasi-experimental	Level 3	Valuing people, individualized care, personal perspectives, and social environment (VIPS) communication skills, 2-4 one-hour workshops over 4 weeks,	Findings suggest less depersonalization, more hope, and more empathy for patients after training. Caregivers reported using more gestures, more humor, asking more yes/no questions, and providing a choice more often after the training.	Small sample size, no randomization, self-report data, not all spoke or read English, so completing the surveys required assistance from the researchers, which could have impacted the validity of the metrics,	Paired t-tests to compare pre and post survey scores. ANCOVA was used for the analysis of time measures.
Rao et al.	2007	36 RCT studies	Systematic Review	Level 1	Reviewing various communication interventions	Physicians who received some sort of communication intervention were	Study only included published data, so potential publication bias,	No statistics

						significantly more likely to elicit patient concerns and exhibit an overall patient-centered approach than controls	which can lead to overestimation of intervention's effect, excluded self reports, which can lead to a conservative view of the intervention's effects	
Roter et al.	2012	197 patients from 4 different practices, and 29 physicians	Randomized controlled trial	Level 2	Patient and clinician web-tool intervention to teach patient-centered communication	Significant increase in both patient and clinician use of patient-centered communication skills and an increase in patient satisfaction with communication in the intervention group. Communication skills can be taught in a computer mediated format both to professional and patients with positive results in patient satisfaction.	Conducted the study in 4 different kinds of practices led to necessary flexibility in the implementation of the intervention, which may have impacted the internal validity. The physician/clinician portion of the study was not randomized, so suffers from self-selection bias. Evaluation was based on self-report, which could result in recall bias	Used a questionnaire before and after the intervention, Intervention impact on patient satisfaction was measured using linear models regression analysis, Wald confidence intervals and Wald Chi-square analysis was used to compare means, t-tests were used for the clinician group as they

								were not randomized to compare pre and post intervention scores related to communication.

Appendix B

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Permission to use the Expanded Four Habits Model (Lundeby et al., 2015)

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Original Wiley figure/table number(s)	Figure 1.1 Model for Improvement on page 24
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Expected completion date	Dec 2017
Expected size (number of pages)	100
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Appendix F

Permission to use the Organizational Performance and Change Model (Burk & Litwin, 1992)

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Author:	W. Warner Burke, George H. Litwin
Publication:	Journal of Management
Publisher:	SAGE Publications
Date:	09/01/1992

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Appendix G

Permission to use SWOT analysis figure (Bryson, 2011).

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Licensed Content Date	Aug 1, 2011
Licensed Content Pages	288
Type of use	Dissertation/Thesis
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Portion	Figure/table
Number of figures/tables	3
Original Wiley figure/table number(s)	Worksheet 32, Creating your own Strategic Plan, SWOT analysis

Appendix H

Pre-Test

Patient-Centered Communication Pre-Test

By completing and submitting this pre-test, you are consenting to participate in this quality improvement project. Please do not place your name on the pre-test. Thank you for your time.

<u>**Demographic Information**</u>
(Please check appropriate boxes or fill in the line)

<u>**Role**</u>

☐ RN   ☐ PCA   ☐ Security

<u>**Age (in years)**</u>

☐ 18-29   ☐ 30-39   ☐ 40-49   ☐ 50-59   ☐ ≥ 60

<u>**Years of Experience:**</u>

As a nurse (if applicable) _____ (in years)

In current role _____ (in years)

1	2	3	4	5
Not at all	**A little**	**Some**	**Quite a lot**	**A great deal**

In actual practice, to what extent: (circle number)

Do you feel confident in communicating with patients with mental illness?
1 2 3 4 5

How often have you experienced an occurrence of physical or verbal abuse in the workplace?
1 2 3 4 5

1) Non-verbal communication is _____ of what you're judged on.
   a. 80%
   b. 50%
   c. 30%
   d. 20%
2) Ego and safety are _____ correlated.
   a. Positively

b. Negatively
c. Not

3)   The keys to effective communication are _____, empathize, ask, paraphrase, summarize.
    a. Learn
    b. Listen
    c. Respond
    d. React

4)   Finish the following quote. "People never say what they mean.....
    a. ...until we meet again."
    b. ...especially when they are right."
    c. ..., especially under stress."
    d. ...until they say it again."

5)   People want to be treated with respect, to be asked rather than being told to do something, to be told why they are being asked to do something, to be given options rather than threats, and given a second chance. These are elements of what?
    a. Truth statements
    b. True Universal Commitments
    c. Statements of Factual Criteria
    d. Universal Truths

6)   The Four Habits Framework for patient-centered communication included investing in the beginning, _____, demonstrating empathy, and investing in the end.
    a. Showing respect
    b. Establishing rapport
    c. Shared decision making
    d. Eliciting patient concerns

7)   Personal face + personal face =
    a. Peace
    b. Fraternization
    c. Conflict
    d. 2

8)   When a patient meets you with his personal face, you must meet him with your:
    a. Tough-guy face
    b. Personal face
    c. Professional face
    d. Clown face

9)   Everything after the word "but" must be:
    a. In legal terms
    b. Spoken loudly
    c. In professional language, tailored and aimed at the goal of the conversation
    d. A curse word

Appendix I

Post-Test

Patient-Centered Communication Post-Test

By completing and submitting this pre-test, you are consenting to participate in this quality improvement project. Please do not place your name on the pre-test. Thank you for your time.

1	**2**	**3**	**4**	**5**
Not at all	**A little**	**Some**	**Quite a lot**	**A great deal**

In actual practice, to what extent: (circle number)

      Do you feel confident in communicating with patients with mental illness?

                                                   1   2   3   4   5

1)   Non-verbal communication is _____ of what you're judged on.
   a. 80%
   b. 50%
   c. 30%
   d. 20%

2)   Ego and safety are _____ correlated.
   a. Positively
   b. Negatively
   c. Not

3)   The keys to effective communication are _____, empathize, ask, paraphrase, summarize.
   a. Learn
   b. Listen
   c. Respond
   d. React

4)   Finish the following quote. "People never say what they mean.....
   a. ...until we meet again."
   b. ...especially when they are right."
   c. ...,especially under stress."
   d. ...until they say it again."

5)   People want to be treated with respect, to be asked rather than being told to do something, to be told why they are being asked to do something, to be given options rather than threats, and given a second chance. These are elements of what?
   a. Truth statements
   b. True Universal Commitments

        c. Statements of Factual Criteria
        d. Universal Truths

6) The Four Habits Framework for patient-centered communication included investing in the beginning, _____, demonstrating empathy, and investing in the end.
        a. Showing respect
        b. Establishing rapport
        c. Shared decision making
        d. Eliciting patient concerns

7) Personal face + personal face =
        a. Peace
        b. Fraternization
        c. Conflict
        d. 2

8) When a patient meets you with his personal face, you must meet him with your:
        a. Tough-guy face
        b. Personal face
        c. Professional face
        d. Clown face

9) Everything after the word "but" must be:
        a. In legal terms
        b. Spoken loudly
        c. In professional language, tailored and aimed at the goal of the conversation
        d. A curse word

Appendix J

Post-Intervention Survey

Patient-Centered Communication Post-Intervention Survey

1) To what extent di d you find value in the Patient-Centered Communication education?
- Not at all
- A little
- Some
- Quite a lot
- A great deal

2) To what extent have you been able to use the tools presented in the Patient-Centered education?
- Not at all
- A little
- Some
- Quite a lot
- A great deal

3) To what extent have you experienced an improved perception of workplace safety since the time you received the Patient-Centered Communication education?
- Not at all
- A little
- Some
- Quite a lot
- A great deal

4) What barriers prevent you from using the Patient-Centered Communication tools in practice?

Appendix K

Letter from Grand Valley State University Internal Review Board

GRAND VALLEY
STATE UNIVERSITY.
www.gvsu.edu

DATE:	July 6, 2017
TO:	Jean Barry
FROM:	Grand Valley State University Human Research Review Committee
STUDY TITLE:	[1092065-1] Implementation of a Patient-Centered Communication Model in the Emergency Department.
REFERENCE #:	18-003-H
SUBMISSION TYPE:	New Project
ACTION:	NOT RESEARCH
EFFECTIVE DATE:	July 6, 2017
REVIEW TYPE:	Administrative Review

Thank you for your submission of materials for your planned research study. Upon review of the aims and description of your study, it has been determined that this project *DOES NOT* meet the definition of covered human subjects research" according to current federal regulations. The project, therefore, *DOES NOT* require further review and approval by the HRRC.

According to your study description, you are conducting a *project to implement patient-centered communication education to emergency department nurses in order to decrease staff injuries. The intent of the project is not to develop or contribute to generalizable knowledge but to generate a scholarly paper.* Therefore, it does not meet the definition of research according to the federal regulations.45CFR 46.102 (d), states that "research is a systematic investigation, including research development, testing and evaluation, **designed to develop or contribute to generalizable knowledge**".

Should you change the aims and activities of your project such that it would then meet the definition of human subjects research, please cease any contacts with potential human subjects until such time as you submit the project protocol to the HRRC and receive the committee's approval to proceed. Should you change the aims and activities of your project such that you are unsure if it meets the definition of human subjects research, please submit a new Non-Human Research Determination Form for review by the Office of Research Compliance and Integrity.

If you have any questions, please contact the Office of Research Integrity and Compliance at (616) 331-3197 or rci@gvsu.edu. Please include your study title and reference number in all correspondence with our office.

"Research is a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge (45 CFR 46.102 (d)).

- 1 -   Generated on IRBNet

Human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains: data through intervention or interaction with the individual, or identifiable private information (45 CFR 46.102 (f)).

Scholarly activities that are not covered under the Code of Federal Regulations should not be described or referred to as *"human subjects research"* in materials to participants, sponsors or in dissemination of findings.

Appendix L

Letter from Mercy Health Saint Mary's Internal Review Board

MERCY HEALTH

MercyHealth.com

NOTICE OF CLINICAL QUALITY IMPROVEMENT MEASUREMENT DESIGNATION

To: Carrie Mull, RN
     Mercy Health Saint Mary's
     200 Jefferson Ave. SE
     Grand Rapids, MI 49503

Re: IRB# 17-0711-3
     Implementation of a Patient-Centered Communication Model in the
     Emergency Department

Date: 07/17/2017

This is to inform you that the Mercy Health Regional Institutional Review Board (IRB) has reviewed your proposed research project entitled *"Implementation of a Patient-Centered Communication Model in the Emergency Department.* The IRB has determined that your proposed project is not considered human subjects research. The purpose and objective of the proposed project meets the definition of a clinical quality improvement measurement. All publications referring to the proposed project should include the following statement: *"This project was undertaken as a Clinical Quality Improvement Initiative at Mercy Health and, as such, was not formally supervised by the Mercy Health Regional Institutional Review Board per their policies."*

The IRB requests careful consideration of all future activities using the data that has been proposed to be collected and used "in order to increase knowledge and understanding of the ED nurses about how to effectively communicate with patients with a mental illness."

The IRB requests resubmission of the proposed project if there is a change in the current clinical quality improvement measurement design that includes testing hypothesis, asking a research question, following a research design or involves overriding standard clinical decision making and care.

Please feel free to contact me if you have any questions regarding this matter.

Brenda Hoffman

Brenda Hoffman, CIM
IRB Chairperson

Copy: File

Institutional Review Board - 200 Jefferson Ave. SE – Grand Rapids, MI 49503 - P: 616.685.6198

Appendix M

Permission to Use Key Stakeholders Figure (Bryson, 2011)

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Licensed Content Date	Aug 1, 2011
Licensed Content Pages	288
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Original Wiley figure/table number(s)	Worksheet 18, creating your strategic plan, Stakeholder Identification

Appendix N

Permission to Use Power versus Interest Grid (Bryson, 2011)

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Licensed Content Date	Aug 1, 2011
Licensed Content Pages	288
Type of use	Dissertation/Thesis
Requestor type	University/Academic
Format	Electronic
Portion	Figure/table
Number of figures/tables	1
Original Wiley figure/table number(s)	Worksheet 21, Creating your strategic plan, Power versus interest Grid

Appendix O

Letter of Permission to Participate in DNP Scholarly Project

MERCY HEALTH
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MercyHealth.com

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AMERICAN NURSES
CREDENTIALING CENTER

June 29, 2017

Carrie A. Mull
2395 Vandyke St
Conklin, MI 49403

RE: Letter of Permission to Participate in DNP Scholarly Project

Dear Ms. Mull,

This letter will serve as permission for you to participate in a DNP Scholarly Project in
collaboration with Mercy Health Saint Mary's in Grand Rapids Michigan. I will serve as your
preceptor at the organization throughout the practicum and project process. In addition, you must
submit your proposed project to the Mercy Health Saint Mary's Institutional Review Board (IRB)
for approval prior to initiation of your project.

Your project titled "Implementation of a Patient-Centered Communication Model in the
Emergency Department" will be conducted as part of the Emergency Department/Behavioral
Health Quality Improvement work. Your project will run in tandem with initiatives involving
Emergency Department, Psychiatric Resource, and Social Work teams, and will require
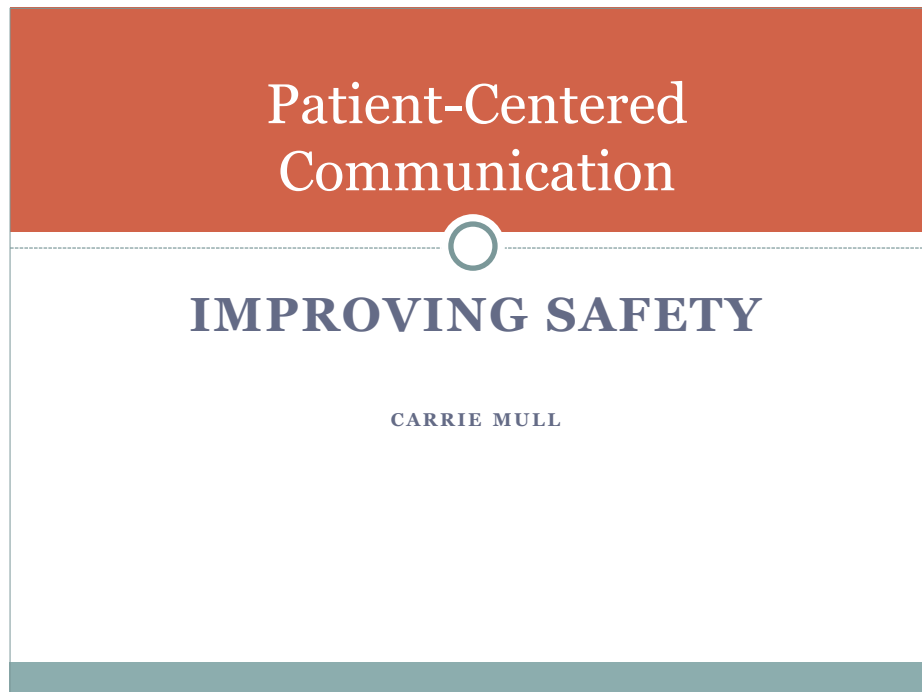implementation, evaluation, and possible re-implementation.

Regards,

Michelle Pena, MSN, RN
Mercy Health Saint Mary's
Clinical Service Director
Emergency/Trauma/Critical Care/Respiratory
penam@mercyhealth.com
Phone: 616.685.6833

Appendix P

Patient-Centered Communication Education PowerPoint

*Double click on slide to view presentation

Appendix Q

Patient-Centered Communication Summary

Patient-Centered Communication—How to talk to patients in order to avoid conflict

- Listen, Empathize, Agree, Partner, Summarize
- Avoid using the inner voice (what you really want to say)
- Pay attention to your triggers and build a trigger guard.
- Personalization (share your name)
- Offer specific praise (thank you for getting into the gown, I know you that was not something you wanted to do.)
  - Should be believable
- Specific praise gets passed along
- Always professional face—not personal face
- Personal face + Personal face = Conflict
- Distinguish between reasonable resistance and severe resistance (let the person say what he wants as long as he does what you say)
- Treat every person as they were the first and only patient you saw today
- You alone have the responsibility to create and maintain continuous rapport
- Always check your assumptions
- The more others pour it on, the better you should play
- Respond, don't react
- Flexibility=strength
- Rigidity=weakness
- Use positive feedback when you least feel like it.
- If a patient is difficult, try going the extra mile for him. He will never forget it.

Only say what you'd be proud to have quoted back to you the next day….by your boss.