Communicating Comfort in Crisis: A Literature Review on Overcoming the Emergency Room Environment to Foster the Nurse-Patient Relationship

Faith Davenport

A Senior Thesis submitted in partial fulfillment
of the requirements for graduation
in the Honors Program
Liberty University
Spring 2022

Acceptance of Senior Honors Thesis

This Senior Honors Thesis is accepted in partial
fulfillment of the requirements for graduation from the
Honors Program of Liberty University.

_____
Cynthia Goodrich, Ed.D.
Thesis Chair

_____
Tamra Rasberry, Ph.D.
Committee Member

_____
David Schweitzer, Ph.D.
Assistant Honors Director

_____
Date

Abstract

The average emergency room patient is not receiving the compassionate nurse-patient communication that patients experience on other hospital floors. Fewer positive nurse-patient interactions prompt patients to state that they feel uncomforted and dissatisfied on hospital exit surveys, inciting hospital management to investigate how to reverse this trend to retain their federal funding. Emergency room nurses cite multiple barriers inherent in their work environment that prevent them from building rapport with their patients, including a layout not conducive to private conversations, strict time constraints, and a fluctuating workload. Working for a prolonged period under these conditions is driving many nurses to quit the specialty and even the profession altogether, putting patients at risk of increased complications due to having a revolving door of novice nurses treating them. Cutting-edge research on nurse-patient communication in the emergency room setting indicates that altering the emergency room layout, implementing a waiting-room nurse practitioner role, and decreasing the nurse-patient staffing ratio are all clinically successful solutions.

Communicating Comfort in Crisis

The current state of the emergency room experience in the United States is not conducive for comforting nurse-patient communication. Nurses have identified many seemingly insurmountable barriers unique to the emergency room environment that quell attentive nurse-patient communication. As it sits, the average emergency room setup does not provide nurses with enough time or energy to build patient rapport, creating a discrepancy between the quality of care that patients receive in the emergency room and other hospital units (Sonis et al., 2018). This repeated lack of communication has been mutually detrimental to the well-being of both patients and nurses, leading to decreased patient satisfaction on hospital exit surveys and increased nurse turnover rates (Perry et al., 2018; Plescia, 2022). Nursing experts have proposed multiple solutions that make opportunities for meaningful patient engagement an ever-increasing possibility in the emergency room. Using the search terms "nurse-patient communication," "emergency room barriers to communication," and "emergency room nurse-patient relationship," several peer-reviewed articles from the PubMed Central, ScienceDirect, and CINAHL databases were compiled and juxtaposed to determine information trends. This literature review will explore current research on the existing barriers to comforting nurse-patient communication in the emergency room and the efficacy of proposed solutions that will address some, if not all, of these barriers.

Current State of Emergency Department Communication

An emergency room is truly one of the most challenging places to be a patient in the hospital. Patients arrive at the emergency room with the highest possible level of stress they have probably experienced in months, only for nurses to meet them with the least amount of

concentrated and compassionate attention in the hospital possible (Sonis et al., 2018). The emergency event that brings the average person to the emergency room is more than likely traumatic and unexpected, causing one to stressfully multitask the economic and social implications of what has just transpired (Cunradi et al., 2021). While the patient's mind is reeling with these new stressors, the last things on his mind are the extent of his injuries, the medications he is currently taking, and his other pre-existing health conditions. After waiting for what feels like an eternity in the crowded waiting room, the nurse ushers him into his cubicle, where she attempts to obtain his family history of heart disease and cancer with her eyes focused on correctly placing his IV (Sonis et al., 2018). As soon as the nurse is in the room, she departs to answer another nearby call light and then a coding patient. Meanwhile, the setting for this chaotic event is punctuated with cries of the next-door patient loudly experiencing his mental breakdown from many stressors.

It is no wonder that more and more patients perceive the emergency room experience as one in which they feel profoundly lonely and forgotten about at one of the most vulnerable points in their lives (Zimmerman, 2019). The nurse who is supposed to be a confidante in the turmoil patients are experiencing is not given the luxury of prioritizing their social and emotional needs. Additionally, emergency room nurses feel emotional burnout and are overtaxed from their workloads. Many of them are opting to leave the specialty and even the profession in droves since the beginning of the COVID-19 pandemic (Yong, 2021). Nursing researchers must identify the multiple barriers to comforting nurse-patient communication in the emergency room setting and address them in clinically significant ways if they want to see this trend of patient and nurse dissatisfaction reversed.

Why Patients Need to Be Comforted

Nurses deem environmental factors inherent in the emergency specialty to be the biggest hurdle to bonding with patients (Sonis et al., 2018). The American Nursing Association Provision 1 outlines that it is one of the primary responsibilities of the skilled nurse to practice with both compassion and respect for the inherent dignity of patients (Fowler, 2017, p. 218). In keeping with these guidelines, American nurses have established their profession as almost synonymous with emotional caregiving and advocacy, making it the most trusted profession in America for 20 years in a row (Gaines, 2022). This legacy of serving in caregiving has prompted patients and their families to culturally perceive nurses as their primary emotional caregivers in the hospital setting. Nurses must then operate to meet patient expectations in an environment that can sometimes feel hostile to deep, genuine human connection. However, this is when communicating comfort to patients is the most necessary, as patients at their most vulnerable are frequently more willing to receive the help they otherwise would have rejected. It has always been the nurse's sacred responsibility to bolster patients in their suffering. Exit surveys on the emergency department (ED) revealed that the patients' top indicators of whether a visit was positive or negative hinged on “staff-patient communication” as first, and “staff empathy” as third (Sonis et al., 2018, p. 104). With all the other things to focus on, such as pain management or waiting times, patients zeroed in on how they were engaged emotionally as indicative of a good hospital experience.

This nurse-patient bond is critical because some aspects of the emergency room, such as chaos and noise, are intrinsic parts of the territory. Nevertheless, patients are more inclined to overlook these aspects if they feel that there is an honest attempt to connect with them on a

personal level: “Given this evidence, our review suggests that ED patients who perceive that their providers are treating them with empathy and are communicating with them adequately may be less dissatisfied with other, less easily improved factors such as prolonged wait times and cramped ED spaces" (Sonis et al., 2018, p. 105). Although the emergency room features its fair share of unique challenges for nurses in their efforts to accomplish this, comforting nurse-patient communication can still occur in the ED as long as these challenges are recognized and addressed (Al-Kalaldeh et. al, 2020). When these barriers are acknowledged and circumvented, patients can tell that their nurses are making an honest effort to engage with them despite the often chaotic environment.

Why Nurses Need to Comfort

Additionally, emergency room clinicians face the highest level of burnout within the medical profession, with 60% of them daily citing a burnout symptom, such as depersonalization or compassion fatigue, compared to 38% in other nursing specialties (Zhang et al., 2020). Burn-out is defined as a state of physical and emotional exhaustion in which the sufferer becomes detached from their sense of self and the meaning behind why they chose the profession that they did (Tavakoli et al., 2018). Although nursing researchers attribute this to a host of environmental factors such as understaffing and severe time constraints, many nurses attest that it is the lack of meaningful engagement with patients over time that causes them to lose their original passion for nursing overall (Hermann et al., 2019). Nurses experience cognitive dissonance in that they still have the desire and expectation of being the patient's emotional caregiver in a setting where they feel they cannot adequately prioritize this role. On other floors, where there are more frequent opportunities to be at the bedside with the patient, the nurse can see the patient repeatedly, follow

up on previous conversations, and bond across multiple shifts. Even when a med-surgical or cardiac nurse is no longer assigned to be that patient's specific nurse, they can still visit that patient when making rounds. Even more so, the nurse can witness the patient progress from a critical state to one in which they experience the joy of healing. The purpose of the emergency room is to stabilize the patient in preparation for that holistic progression elsewhere on another hospital floor that can more effectively serve their specific patient needs.

Emergency room nurses also face increased exposure to more of the emotionally taxing aspects of the profession, such as attempting to revive a coding patient, losing the aforementioned patient, and having to confront the family about the loss. Although this tragedy does occur on other floors, it is statistically rare compared to how commonplace it is in the ED, with 1 in every 500 patients dying in the first 2 hours of admission (Kongsuwan et al., 2016). Repeated exposure to the disheartening aspects of nursing, such as not seeing the patient improve or even survive, coupled with a high level of stress, can cause the most resilient of nurses to walk away from the profession altogether (Kongsuwan et al., 2016). This knowledge makes fostering positive nurse-patient interactions, even small ones, incredibly important.

Emergency room nurses must experience genuine human connection with their patients before transferring them to another floor to become invigorated in their work again. The ratio of positive patient experiences to negative patient experiences must be balanced to prevent burnout. Preventing burnout is critical in modern nursing because nurses must remain on the same floor for a long enough period to attain an autonomous level of competency. The Patricia Benner Novice to Expert nursing theory postulates that a novice nurse must progress through five distinct stages of competency to reach the expert level, wherein the nurse becomes confident in

her intuition and clinical judgment in complicated patient situations (Ozdemir, 2019). Since most 4-year degree nursing programs teach broadly about multiple specialties to create a well-rounded beginner nurse, the nurse must acquire skills on the job for their particular specialty. Patient well-being and health outcomes depend on nurses staying on the same unit long enough to specialize and acclimate their skillsets entirely. When nurses leave emergency medicine because they feel overwhelmed and emotionally disconnected from their patients, patients will ultimately suffer. They receive a revolving door of new staff unaccustomed to the unit and its unique pressures (Bruyneel et al., 2017). The symbiotic nurse-patient relationship depends on the patient's capacity to receive comfort and the nurse's opportunity to give it. Environmental factors cannot be an excuse for why this exchange is not occurring in the emergency room.

How to Help Them Both

From the previous two points, it is abundantly clear that nurses acknowledge their social role as the patient's emotional caregiver and desire to fulfill that role to prevent emotional burnout and subsequent staff turnover. Since emotionally comforting nurse-patient interactions are edifying for both the nurse and the patient, why are they not happening more in the emergency room? As more and more hospital reviews and surveys reveal a trend of patients communicating feelings of loneliness and isolation in the emergency room, there must be a necessary reprioritization of this critical nursing element throughout the specialty (Johns Hopkins, 2016). As with all patient needs, it is the responsibility of the healthcare team to foresee and meet them to the best of their ability. Nurses can know that patients have a higher likelihood of arriving at the ED as frightened, anxious, angry, or stressed individuals because of the critical nature of their injuries. Herein lies an excellent opportunity to establish trust with

patients for the duration of their hospital stay and allay the fight or flight response that could jeopardize their healing process. Taking care of the physical needs of patients while simultaneously prioritizing their emotional needs is not just good nursing. It is nursing. The American Nurses Association (2022) defines nursing as both the "protection, promotion, and optimization of health and abilities," as well as the “alleviation of suffering through the diagnosis and treatment of human response” (para 2). Identifying and relieving emotional suffering are indispensable pieces of the whole nursing profession. Undoubtedly, implementing more opportunities to communicate comfort in the emergency room will be difficult, as many immovable barriers inherent in the unit will have to be addressed and circumvented. Solutions to this problem must operate within the unique layout, time constraints, and workload of the emergency room. These solutions must also address one or more of these factors in an emotionally meaningful and statistically significant way for hospital management boards to implement them. This paper will serve as a literature review of how the recent literature proposes to overcome the primary barrier preventing nurses from being able to have more meaningful patient exchanges: the environment of the ED itself.

Specific Barriers Within the Environment

When asked about what they felt was the most prominent barrier to heartfelt interactions with their patients, multiple nurses identified the environment of the emergency room itself to be the most insurmountable one on a daily basis (Tindle et al., 2020). Because the definition of the word “environment” can be somewhat ambiguous, it has been subdivided into three key aspects: layout of the environment, severe time constraints, and patient workload. Although these aspects of care are a challenge for every nurse, regardless of floor assignment, the subsequent paragraphs

will thoroughly explain how the emergency room takes these communication barriers to the extreme.

The Layout of the Environment

Emergency room nurses are tasked with creating feelings of warmth and safety for their patients in an environment with swinging doors to the streets of the outside world. The ED structure is crafted for the necessities of practicality and efficiency, with a floor plan that is arranged to allow easy access from one area to the next. For multiple healthcare workers to hear and get to critical patients quickly, this setup often includes curtains instead of walls and an open floor plan that allows voices to carry. For this reason, patients are often self-conscious about how exposed and vulnerable they are in this large setting. Patients can withhold valuable medical information that could potentially influence the kinds of medications and treatments prescribed to them because they do not feel comfortable disclosing personal information in an open environment. The overall lack of privacy that the ED affords can make communicating bad news, such as sudden death in the family or a scary diagnosis, unnecessarily more traumatizing (Villalona et al., 2020). Not only can people hear the noise that carries across the expanse of the ED, but they can also see from one end to the other. Patients do not want to grieve one of the worst moments of their lives in the full view of strangers. When nurses have the means to build rapport with a patient early on in the visit, they lay a foundation of trust from which they can operate for the rest of the patient's stay. By intentionally taking time to present oneself as the patient's advocate, the nurse provides the patient with a confidante with whom they can disclose sensitive medical information (Villalona et al., 2020). In an unexpected tragedy, the patient can return to this newfound confidante to weather bad news together.

Time Constraints

Another unique challenge that the emergency room presents to nurse-patient communication is severe time constraints. In fact, ED clinicians identified "lack of time" as the paramount reason they could not provide as much emotional comfort to patients as they wanted to within the given shift (Pun et al., 2015, p. 7). Many of the life-threatening conditions that arrive at the ED have a quality-control countdown timer that starts when the hospital admits the patient. One of the most well-known examples of this is the door-to-balloon procedure. In this procedure, clinicians have a 90-minute window to identify and open the occluded vessel of a newly admitted heart attack patient (Tungsubutra & Ngoenjan, 2019). If they cannot do so, they have not met a quality assurance metric, an action heavily monitored by the hospital management and medical licensing agencies to ensure that a particular hospital is carrying out best practices. This type of metric is somewhat unique to the ED in that the metrics of other hospital floors have more to do with the cleanliness of care (e.g., prevention of catheter-associated urinary tract infections) and less to do with its speed.

Another source of time-associated pressure that nurses on other floors do not experience is that the emergency room connects directly with a waiting room. To maintain a workflow of patients in and out of the emergency room, clinicians must move patients effectively from the waiting room to the emergency room, and finally to whichever floor matches their specific medical needs. Patients that are stressed and in pain in the waiting room often become angry and even violent in response to waiting for upwards of three hours to be seen. Chaos in the waiting room can stress nurses to move physically stable patients quickly through the system, regardless

of their emotional state. Hospital management has a set time frame, known as the four-hour treatment window, that the hospital must discharge the patients within to prevent patients from reaching a boiling point in the waiting room (Forero et al., 2019). Because clinicians know little about the patient's health history upon admission (entire medical records missing in some cases), their foremost tasks to be accomplished are diagnostic. The initial portion of the patient's workflow through the ED is mainly within the nurse's control, such as assessments and establishing lines and leads. However, the next portion for most patients involves outsourcing them to other specialists on a nearby unit, such as X-ray or CT, which is outside of the nurse's control (Choi & Kang, 2021). A rapidly filling waiting room coupled with the pressure to maintain the same quality of care to meet expected standards pushes nurses to exhaustion.

The revolving door of patients with the expectation of rapidly moving them through the ED can make nurses feel that trying to build rapport with their patients is not just an uphill battle but a losing one. When hospital management only tracks how long it takes the medical team to triage, assess, and handoff each patient as a quality measure, they inadvertently communicate to nurses that this is the primary way their success as a nurse is being scored. In critical situations, nurses subconsciously know that the speed and number of patients is the emphasis of care, with aspects like nurse-patient communication comprising whatever portion of time is leftover (Ramsey et al., 2018). However, because of the time constraints that caused this prioritization in the first place, there is little to no time left over before patients have to be transferred. In order to provide patients with emotional comfort before handing them off to the next hospital unit, emergency room nurses must become creative about how they make the most of the limited time they have with each patient. Some nurses attempt to multitask their medical and emotional

responsibilities to their patients by asking them questions or offering encouragement during the assessment. Despite their noble efforts, nurses should not have to squeeze inpatient encouragement between pressing tasks. These short spurt conversations lack the sustained attention and eye contact necessary to establish lasting patient trust (Dang et al., 2017). Additionally, they do not allow the patient the emotional space to share vulnerable health information or express cultural or religious preferences that might alter future compliance in care (Dang et al., 2017).

When nurses constantly delay or shorten soothing conversations with patients to prioritize medical care, patients receive the subliminal message that their caregiver is committed to their physical well-being, not necessarily their emotional well-being. Over time, patients begin to bite their tongues about their concerns or become emboldened to assert their needs in displays of rage or stress that can be incredibly demoralizing to the medical team and other patients (Dang et al., 2017). In either case, the patients still do not feel that the nurse, the person they have come to perceive as their sole emotional caregiver, is listening to them. For emergency room nurses to fulfill this pivotal role, the solution proposed must provide them with the necessary time to build genuine rapport with their patients while they are still in the emergency room.

Workload

Another aspect of the emergency room environment that stifles the genuine connection between the nurse and patient is the sheer workload per nurse. The usual one-to-four nurse-patient ratio in the emergency room can become one-to-six and one-to-eight during peak busy times (Lyneham, 2016). With this degree of work to accomplish, many nurses operate under the false belief that they should accomplish their best in the time they have. They lean on the hope

that another nurse will provide whatever emotional comfort they cannot provide for the patient on the floor to which the patient transfers. However, according to a study from Olivet Nazarene University, only 13.3% of all emergency room patients are admitted to the hospital for any length of stay (Olivet Nazarene University, 2020). By hoping that another floor picks up the emotional slack, some distressed patients are discharged to the community again, never having experienced sustained compassionate attention from a nurse. This means that the patients' perceptions of the care they receive in the emergency room are not just their first impression of the hospital but their only impression of it. The adage “You never get a second shot at a first impression” applies here in that patients form their beliefs and trust surrounding medicine from their hospital experiences.

The workload of the emergency room is also notorious for being one that fluctuates wildly, as patients can come in with injuries varying from a sprained wrist to left-sided weakness related to stroke. On other units such as intensive care, most hospital managements require nurses to have a one-to-one nurse-to-patient ratio because they only care for critically ill patients. Since emergency room nurses take care of an array of patients with varying severities of illness, hospital management gives them a more liberal nurse-patient ratio, usually one-to-four. When one of their four patients' conditions suddenly devolves into being critically ill, however, they are left with the workload of an intensive care unit nurse with the staffing ratio of an emergency room nurse. When all of her attention is on stabilizing the critically ill patient, she can postpone care to her other three other patients, whose injuries are at different levels of severity. The unique ebb-and-flow nature of the emergency room causes nurses to be both in and out of a sustainable nurse-patient ratio throughout their shifts (Chan et al., 2010).

Another adverse effect of the heavy workload experienced by nurses is frequent interruptions in their thought processes. Their workload also causes them to postpone providing patient care to complete non-nursing tasks. In hospitals with unsafe nurse-to-patient staffing ratios and few technicians, nurses must fulfill multiple roles that management would usually delegate to emergency room technicians. Technicians can obtain vital signs, start IVs, and place ECG leads. With these preliminary tasks out of the way, nurses have time to do tasks that require the critical thinking associated with their level of expertise, such as interpreting the ECG rhythm and requesting the correct medication to treat it from the doctor. Most importantly, nurses get to remain in their "nursing mode" longer without sporadic losses of attention and disruption of activity.

Although these distractions may seem an inevitable part of working in a chaotic environment, multiple studies have shown that the number that emergency room nurses face are potentially fatal to patients. Nursing researchers assert that hospital management must be proactive about minimizing unnecessary multitasking: “Because repeated interruptions can increase the risk of errors, department managers should involve other clinician leaders in identifying interventions and procedural changes to mitigate or eliminate low-priority interruptions” (Forsyth et al., 2018, p. 622). The majority of the aforementioned errors are life-threatening medication errors of both dosage and type and communication errors in obtaining a thorough patient history, leading to future prescription errors or incorrect diagnoses. Emergency room nursing researchers Jessica Castner and Heidi Suffoleto (2018) note that, “Fragmenting the clinician’s workflow, through interruption, is a patient safety and flow issue by taxing the accuracy of memory, increasing errors on decisions made on similar patients, increasing the time

to re-orient and complete the original task, and escalating the inaccuracies in completing the primary task" (para 6). Even the most expert nurses under the weight of an unsustainable workload are apt to make these errors, leaving time to step into their emotional caregiver role sparser than ever. When every minute of the nurse's attention is necessary to maintain patient safety, there is very little to no time to set aside for intentional emotional engagement with the patient.

The Solutions Addressing These Barriers

From the previous paragraphs, it is clear that for the mutual benefit of both nurses and patients, there must be more intentional conversations to communicate comfort happening between nurses and patients. The barriers to these necessary conversations are well ingrained within the environment of the emergency room itself, which has prompted nurses to accept fewer positive nurse-patient interactions as an inevitable part of choosing emergency medicine as their specialty. However, neglecting the indispensable emotional caregiver role can never be acceptable, even in environments that make it more challenging to accomplish than others. Current evidence-based research highlights the following three solutions as being adept at surmounting barriers of environmental layout, time constraints, and workload to increase patient satisfaction in nurse-patient interactions: creating an alternative layout; implementing a waiting room-specific nursing role; and decreasing the nurse-patient staffing ratio.

Solution 1: Alternative Layout

The first and easiest solution to increasing comforting nurse-patient communication in the emergency room is to change the room's environment to facilitate more frequent and better-quality communication. Nursing researchers have statistically demonstrated that nurses spend

most of their time communicating in nurse-to-nurse communication rather than nurse-patient and nurse-physician (Real et al., 2017). Researchers hypothesize that the environment of the nurse's station could be a critical contributing factor to why this phenomenon exists (Real et al., 2017). The classic layout of the emergency room features a centralized nurse's station surrounded by multiple tiny patient rooms, or cubicles, with transparent glass walls or pull-back curtains. Nurses can hear and see what is happening within each patient's cubicle from the centralized station. When a nurse needs to update another nurse on a patient's care plan, they are accustomed to returning to the nurse's station to convey that information to a colleague. However, current patient feedback reveals that patients feel isolated from their treatment plan when nurses return to the centralized station to have conversations surrounding their care (Fay et al., 2019). Keeping the nurse in the patient's room or in closer proximity provides more opportunities for nurses to educate and build rapport with patients (Elkholi et al., 2021). The ideal layout would make nurse-patient communication equal to or greater than clinician-to-clinician communication and take place more often at the patient's bedside (Fay et al., 2019). By having multiple decentralized nursing "pods" throughout the emergency room, nurses have more conversations with the physician and other nurses directly over the patient's bed, rather than in the hallway or at the centralized station, which excludes the patient (Fay et al., 2019). A decentralized nursing station allows emergency room nurses to participate in the mutually edifying bedside nursing experience that their colleagues on other floors do more of the time. By having a less unified meeting place for nurses and physicians, the environmental structure coaxes clinicians into having conversations about patient care wherever the patient is.

The decentralized nurse's station solution has also scored remarkably well with patients

on HCAHPS exit surveys, short for Hospital Consumer Assessment of Healthcare Providers and Systems (Fay et al., 2019). The federal government requires hospital management to provide discharged patients with these surveys in compliance with Medicaid and Medicare quality assurance protocols. Consistently negative patient reviews of hospitals and clinicians can force the hospital management to pay out of pocket for patients who can not afford their treatment. HCAHPS exit-surveys from three different studies revealed that EDs with a decentralized nursing station scored the highest in three key indicators of patient satisfaction: "promptness in response to call," "remaining informed by the nurses," and "nurse attitude toward patient/family requests" (Grimes et al., 2017, pp. 42-43). An additional study echoed these results, with those units featuring decentralized nursing stations scoring consistently higher in all patient satisfaction parameters than their single centralized nursing station counterparts (Friese et al., 2014). Patients are more inclined to voice their concerns with a nurse that they consistently see seated directly outside their bedroom. Emergency rooms with a layout of multiple nursing station pods dispersed among the patient rooms are aptly coined "neighborhoods" to express the community they hope to achieve (Fay et al., 2019). By changing the emergency room layout, researchers are hoping to change the entire emotional atmosphere of the room and, subsequently, the nurse-patient dynamic.

This solution is not only more cost-effective than the two following ones, but it is also the most easily implemented without the hiring and training required for implementing new staff (Fay et al., 2020). The currently hired and skilled staff learn to operate differently in a new environment and become accustomed to the new layout over time. The downside of this solution is that modern research has not proven its success in surmounting the barriers of time constraints

or workload in any statistically significant way, only in layout. Although increasing nurse-patient communication will aid in nurse retention and patient satisfaction, this solution does not address the ebb-and-flow patient load of the ED like the following two solutions do (Fay et al., 2020). When addressing a sudden spike in new patients or surmounting the barrier of time constraints, having more workers and implementing specialized roles for communication are better long-term solutions.

Solution 2: Waiting Room Specific-Nurse

Another solution to increase patient satisfaction while overcoming the emergency room environment is assigning a nurse specifically for the waiting room post-triage area (Innes et al., 2019). When there is no treatment space available for patients, they are moved to a waiting area and placed in a queue based on the severity of their injuries. Traditionally, these patients are taken care of only by a triage nurse specializing in clinical decision-making and advanced assessment techniques. However, the role of the waiting room nurse has taken significant precedence in recent literature because the problem of overcrowded waiting rooms has gone from a rare occasion in the emergency room to an expected daily occurrence (Savieto et al., 2019).

Having an experienced nurse practitioner work alongside the triage nurse has been repeatedly shown throughout recent studies to increase patient satisfaction and safety within the ED (Innes et al., 2019). Although the nursing boards have not officially established the exact qualifications for this role, they are clear that the individual must be well-versed in the clinical skills of emergency medicine. With that skill set as her foundation, her role's emphasis becomes her ability to soothe and ensure patient safety throughout the triage process (Innes et al., 2021).

The waiting room nurse would be adept at non-verbal communication (reading and exhibiting comforting body language), conflict de-escalation techniques, and the art of rapidly developing rapport with waiting patients and families (Innes et al., 2018). In this way, she ensures that each patient receives one-on-one attentive listening at the height of their stress from a nurse right away. By having a waiting-room-specific nurse, hospitals ensure that all patients will receive a positive perception of medical caregivers and emotional comfort before leaving the emergency room to another hospital floor or re-entering the community.

Additionally, this solution addresses the barriers of time constraints and workload by making the waiting room environment a better holding place for patients until the other nurses can attend to them. Implementing the role of the waiting room nurse practitioner is particularly effective at addressing the barrier of time constraints. Emergency room nurses are relieved of the pressure that the waiting room is overflowing into their workspace by delegating that task to the waiting room nurse. Because waiting room nurses can establish the nurse-patient therapeutic relationship from the time the patient enters the hospital's front door, they set up their colleagues for success by providing them with calmer, less defensive patients (Innes et al., 2021). Johns Hopkins Department of Emergency Medicine (2016) found that implementing a waiting room nurse caused emergency room nurses to be more than twice as likely to report more positive interactions with patients when they arrived from the waiting room.

Furthermore, patients were 14% less likely to report "Never" when asked if they had been updated on their plan of care throughout their emergency room stay in hospital exit-surveys (Johns Hopkins, 2016). By having a waiting-room-specific nurse to begin the process of emotional stabilization and building rapport with patients, the workload of all the subsequent

nurses will decrease as they only have to build upon her previous work. Waiting room nurses can collect a more thorough patient history, identify cultural and religious needs, and pass that information onto the next nurse to create a unique patient experience in which the patient feels genuinely listened to.

The waiting room nurse also relieves nurse workload by serving as a patient educator in two different ways (Innes et al., 2018). Firstly, the nurse clarifies the ED processes to the patients and their families, which helps to absolve confusion and distress about what happens next. Communicating why there are delays in care and providing frequent updates of their place in line has been shown to decrease patient agitation significantly (Innes et al., 2018). Patient satisfaction is drastically improved when patients have a familiar face making rounds to check their condition and prompting them to let her know if they begin to feel worse or have questions (Innes et al., 2018). Secondly, waiting room nurses are skilled enough to help patients in the emergency room with non-urgent injuries through education. For example, if a patient comes to the emergency room stating that they have a second or third-degree burn, the waiting room nurse can assess the patient's wound and determine it to be mild skin irritation, not a burn. The waiting room nurse can educate them on how their injury is not severe and what local treatment to seek next. In this way, an emergency room nurse will never have to multitask with this patient among her other critical ones. The waiting room nurse has already listened to and addressed this patient's needs in the waiting room itself (Innes et al., 2018). In current waiting rooms with just a triage nurse, the aforementioned patient with a minor skin injury will become frustrated as his treatment is delayed in favor of more critically injured patients. Unless hospitals implement a waiting room nursing role, many patients like him will leave the hospital feeling unheard and

without instructions on what to do next.

Solution 3: Safer Staffing Ratios

Among all the possible solutions suggested, implementing safer staffing ratios is undoubtedly the most effective at increasing patients' overall satisfaction with their quality of nursing care (Ramsey et al., 2018). When nurses are not stretched thin from doing the work that should have been allocated to emergency room technicians or split among their colleagues, they are allowed to do the job they signed up for, especially their role as emotional caregivers. Even though the aforementioned quality time metrics still exist under this solution, nurses have more time remaining than usual for each patient because they do not have as many patients (Ramsey et al., 2018). Having a larger workforce enables them to meet the quality time metrics goals set out by licensing agencies without sacrificing patient safety and emotional succor (Ramsey et al., 2018). Additionally, when nurses have more time with their patients, they can use that time to delve into more meaningful forms of communication featuring open-ended questions and sustained eye contact. Patients who perceive that their nurse is actively trying to engage with them can better emotionally regulate with the nurse and feel encouraged to voice concerns and preferences regarding their treatment.

Furthermore, having a nurse-to-patient ratio of one-to-three instead of one-to-four means that nurses are better able to shoulder rapid fluctuations in workload from having one of their patients suddenly deteriorate. Having work pile up to a reasonable extent is unavoidable in these circumstances. However, the amount of work that the nurse returns to after stabilizing one of her patients should not be the insurmountable amount that it currently is in most hospitals. By having two patients instead of three to return to, the nurse has more time leftover to divvy up among her

patients for social and emotional interventions specifically. With more colleagues to shoulder the workload, nurses have the time and energy to add these interventions to their care plan as a distinct block of time dedicated to communicating comfort rather than a goal they hope to achieve while multitasking their other obligations.

The most considerable downside to this proposed solution, and subsequently why more hospital managements do not implement it, is that hiring more nurses and emergency room technicians is inherently expensive. Nursing salary comprises the most significant percentage of the hospital budget, with hospital management allocating over 30% of the monthly budget to their wages (U.S. Bureau of Labor, 2020). However, hospital management systems that believe they are saving money by not hiring more nurses or technicians are only doing so in an initial, temporary way. Each percentage change in nurse turnover increases or decreases the budget of an average hospital by an amount of $270,800 per year (Plescia, 2022). Additionally, finding and retraining new nurses to fill the places of those that quit costs hospitals $40,038 on average per nurse (Plescia, 2022). This exorbitant amount does not consider the money hospitals lose in reimbursing patients for medication errors or complications related to incorrect diagnoses from insufficient patient histories. The relationship between decreased nurse-patient communication and increased critical patient incidents is well established throughout modern research (Pun et al., 2015). Since nurses spend the most time at the bedside with the patient compared to anyone else on the medical team, they are adept at catching subtle changes in patient mood and presentation that could signal an impending stroke or heart attack. The time constraints that nurses face also increase when there are too many patients for each nurse. For every three additional patients that nurses care for in 24 hours, the waiting time for patients to receive a

diagnostic evaluation that can identify life-threatening internal injury doubles (Shindul-Rothschild et al., 2017).

Ultimately, the primary reason major hospital corporations do not invest in empathetic communication by making necessary changes like those suggested is that they do not perceive it as a priority. To them, nurse-patient communication is an extraneous part of patient care that does not carry the same effect on the hospital's bottom line as the other aspects of care do. Spending an extra ten minutes to help a patient emotionally decompress after receiving devastating news is not a measured quality metric for nurses like the door-to-balloon procedure. However, that does not mean that the repeated neglect of the soft skills in the emergency room will not eventually backfire against the hospital through patient satisfaction surveys. To remain compliant with the Affordable Care Act's stipulations, hospitals must send satisfaction surveys to discharged patients featuring questions like, "During this emergency room visit, how often did nurses listen carefully to you?" and "During this emergency room visit, did nurses spend enough time with you?" (Ye et al., 2022). Too many responses in the negative to these questions prompt the federal government to cut reimbursement to that hospital forcing them to eat the cost of medical care from patients who cannot afford to pay for part or all of their bills (Ye et al., 2022). Questions related to patient satisfaction contribute to almost a third of the total performance score on these surveys, making it a key hospital quality indicator (White et al., 2019). Having multiple technicians and a safe nurse-to-patient staffing ratio gives nurses more time to step into their emotional caregiver role with each patient.

Conclusion and Recommendations for Further Research

Hospitals must make fundamental changes in the current way emergency rooms are run

not only for patient safety and comfort but also for the mental health of nurses. The lack of nurse-patient bonding in the ED affects both parties negatively and the hospital experience overall. It is not a lack of nurse initiative or patient reception preventing these positive interactions from happening, but rather an environment rife with barriers that are hostile to building and maintaining the nurse-patient connection. The primary obstacles that have been identified and established throughout the literature are hospital layout, time constraints, and nurse workload. It is the responsibility of hospital management to address and overcome these barriers to the best of their ability. The future of the medical field cannot afford to have any specialty, any ward, any practice where the emotional comfort of patients is not treated as a priority by clinicians and management alike. It is not only expensive, dangerous, and unprofessional but also an affront to the practice of medicine to neglect this indispensable aspect of the trade.

Modern nursing research has identified changing the layout of the hospital environment, implementing a waiting-room nurse role, and decreasing the nurse-patient staff ratio as possible solutions for best practice going forward. When hospitals create an emergency room where nurses can have these consoling conversations with their patients, both nurses and patients can achieve peaceful symbiosis. Nurses receive the peace that comes from fulfilling their role as listeners, and patients receive the peace that they are being listened to. Nursing researchers White et al. (2019) have discovered that burnout nurses who feel unsupported by administration almost always have patients that report lower satisfaction scores and more adverse events (e.g., receiving the wrong dosage) than non-burnout nurses. One such study that followed 687 direct care nurses throughout their shifts revealed burnout nurses were five times more likely to forego

necessary, possibly life-saving patient care than their non-burnout colleagues (White et al., 2019). For the HCAHPS surveys, patients who received care under a non-burnout nurse were 5% more likely to recommend the hospital to a friend than those who received care under a burnout nurse (Brooks et al., 2021). Patient satisfaction, patient recommendation, and the number of adverse patient events all affect whether a hospital will continue to receive a consistent level of government funding or must pay out of pocket for those who cannot afford services (Brooks et al., 2021). Hospitals that provide nurses with adequate resources to accomplish their tasks and a work culture where they can freely verbalize and influence the changes they want to see have fewer burnout nurses overall (Brooks et al., 2021). Wherever the nurse-patient therapeutic relationship is strengthened and prioritized by hospital management, patient satisfaction and safety will continue to increase.

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