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Using Video Simulation to Enhance RN-PCA Communication

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Fall 2014
Abstract

The purpose of this project was to develop a video simulation exercise to enhance communication between Registered Nurses (RNs) and Patient Care Assistants (PCAs). From a general microsystem assessment initially performed on an urban hospital medical-surgical unit, 75% of respondents noted that the most pertinent issue to address was improving communication between RNs and PCAs. Literature review of evidence-based practices found several studies that support the use of human clinical simulation to promote teamwork and interdisciplinary communication. RNs ($n = 24$) and PCAs ($n = 9$) were then individually interviewed with surveys and responses scored based on the Likert Scale. Pre-test survey results reflected differing opinions about various communication aspects between RNs and PCAs. Improving communication during delegation was chosen as the theme of the simulation project. Two short videos were created featuring an RN and PCA performing an effective and ineffective hypothetical scenario. As the intervention, the videos were shown to unit RNs and PCAs who were previously surveyed. Participants were then debriefed before completing a post-test 3-item survey to evaluate their perceptions of what they saw. Despite a small $n$ value of 8 RNs and no PCAs, all post-test respondents believed the video simulation successfully demonstrated effective and ineffective communication and were encouraged to reexamine their own communication styles. The debriefing narratives from the RNs revealed support to develop more simulation videos and incorporate them into future Staff and Patient Council Meetings.
Effective communication between Registered Nurses (RNs) and Patient Care Assistants (PCAs) is the foundation for providing safe patient care in the healthcare setting. Maintaining open and proactive communication between RNs and PCAs depends on a wide range of factors, from individual work ethic to unit culture shaped by the systemic protocols of an institution. Furthermore, challenges in communication between RNs and PCAs are not new. The inherent occupational hierarchy between nurses and patient care assistants can result in misperceptions and communication difficulties between staff. With healthcare in this country changing within the last several years due to rapidly shifting demographic trends, the digitization of medical records, and revisions to the national health insurance industry, it is only natural that such changes will ultimately impact those who serve at the frontline of patient care – RNs and PCAs. Changes in healthcare are inevitable and will continue to impact the complex working relationship between nurses and patient care assistants.

It is thus imperative to determine the root(s) of the communication challenges between RNs and PCAs. How can RNs more effectively communicate with the PCAs they work with? How can PCAs more effectively communicate with the RNs they work with? What is the source of the most critical communication challenge between RNs and PCAs? What is the most appropriate evidence-based intervention to implement on the hospital unit that can help improve staff communication in the most cost-effective and collegial manner?

**Rationale**

To rationalize implementing change to a unit, a general microsystem assessment was first conducted on a 36-bed medical-surgical unit at a large, urban teaching hospital. This particular unit was budgeted for an average daily census of 33.4 and had a skill mix of approximately 80% Registered Nurses and 20% Patient Care Assistants during a shift. RNs worked 12-hour shifts
while PCAs generally worked 8-hour shifts. The core staff consisted primarily of a Patient Care Manager, Assistant Patient Care Manager, Registered Nurses, Patient Care Assistants, Patient Service Assistance, and Unit Service Coordinators. Staffed for a ratio of 4-5 patients per nurse, the medical-surgical unit served a demographically diverse patient population that was primarily adult and geriatric between the ages of 18 to 90 years old.

Roughly half of the RNs and PCAs initially surveyed agreed that the unit was a better place to work than it was 12 months ago. All of the staff surveyed indicated that the work environment was somewhat stressful. The most frequently cited inpatient unit processes that could be improved were: routine care; discharge; feeding patients; fall risk monitoring; answering patient call lights; and materials/equipment management. However, when RNs were asked what would make this inpatient unit better for patients and staff overall, the majority of respondents (75%) indicated improved RN-PCA communication. Although each of the aforementioned unit processes warrant investigation for improvement, it became apparent from the staff surveys that improving overall communication between RNs and PCAs was a chronic issue on the floor and the most critical component affecting patient care on this particular unit. See Appendix A for the Root Cause Analysis.

**Literature Review**

Literature review of evidence-based practices was conducted to support the need to implement a communication improvement project. Licensed nurses, besides providing specialized nursing care, are fundamentally responsible for supervising nursing assistants. Because of their supervisory role, the attitudes and views of RNs can be expected to play a major role in determining the quality of care delivered by nursing assistants (Schirm, Albanese, Garland, Gipson, & Blackmon, 2000). Power relations among nursing staff in any institution are
innately complex. There is indeed a history of class conflict and power struggles within the nursing discipline (i.e. nursing aides resistance to nurses’ domination). Jervis (2002) indicates that while management and higher-level staff stressed the importance of clearly communicating expectations to nursing aides for staff comportment, there tended to be a lack of reciprocity. Conflicts played out between RNs and nursing aides may have its root not simply in personality conflict or work performance but ultimately the medical monopolization of healthcare and related struggle of nursing to win greater professional status (Jervis, 2002).

Rubin, Balaji, and Barcikowski (2009) investigated barriers to RN and nursing aide communication at a southeast Ohio nursing home and concluded that nurse supervisors are key to educational reform and must be taught collegial methods when delegating authority. Communication collegiality includes active listening, compassion, respect, trust, empathetic curiosity, intuition, cultural sensitivity, and non-judgmental attitudes (Rubin et al., 2009). Teamwork must permeate all levels of the nursing hierarchy and a mission emphasizing mutual dialogue and empowerment must replace condescension. The implication for nursing management is to develop multidisciplinary educational tools to foster communication and collegiality, thereby reducing job turnover (Rubin et al., 2009).

Another study by Scott-Cawiezell et al. (2004) addressed the issue of nursing hierarchical conflict by exploring nursing home staff’s perceptions of communication and leadership to facilitate quality improvement. Leadership and clinical staff were surveyed to characterize the perception of communication, leadership, and overall work environment. Openness, accuracy, timeliness, satisfaction, and understanding of communication are concepts that despite education, race, ethnicity, and role, nursing staff appeared to have shared meaning (Scott-Cawiezell et al., 2004). However, RNs and other professionals perceived communication as better than nursing
assistants and CNAs perceived less timely communication than RNs (Scott-Cawiezell et al., 2004). Survey respondents were least positive with all aspects of the accuracy of communication, which can significantly impact patient care (Scott-Cawiezell et al., 2004).

In a qualitative descriptive study by Potter, Deshields, & Kuhrik (2010), the RN and nursing assistive personnel (NAP) described conflict as a central theme during delegation. Sources of conflict varied between RNs and NAP: five sources of conflict from the RN interviews included age, work ethic, role, personality, and management. NAP however focused on work ethic, role, and personality as main sources of conflict with RNs. Inconsistent change of shift reporting also presented as a communication chasm between RNs and NAP (Potter et al., 2010). When the RNs and NAP did not begin a shift of care with a complete patient report, the delay in communication proved difficult for RNs and NAP to share expectations, clarify tasks, and reach agreement on timelines for care (Potter et al., 2010).

Successful delegation depends on quality of RN and NAP working relationships, timely ongoing communication, personal initiative, and willingness to collaborate (Potter et al., 2010). RNs would benefit from acquiring competency in how to conduct reports, resolve conflicts, and how to convey their role in patient care management. Nursing assistive personnel would benefit from developing competency in using effective communication skills for giving feedback, clarifying tasks and patient status, and resolving conflict (Potter et al., 2010). One approach to enhance communication between RNs and NAP would be to develop human clinical simulation scenarios that involve RNs and NAP learning to resolve delegation conflicts, deliver reports, and prioritize tasks on simulated patients (Potter et al., 2010).

Another study by Mager, Lange, Greiner, and Saracino (2012) also proposed adopting simulation pedagogy to enhance teamwork and communication in the care of older adults.
through the Expanded Learning and Dedication to Elders in the Region (ELDER) project. During the three-year project exploring best practices in geriatric care, more than 100 providers working in nursing homes, clinics, and long-term care agencies confirmed the need for improving communication and collaboration between RNs and NAs (Mager, Lange, Greiner, & Saracino, 2012). To accomplish these goals, three simulated patient scenarios using human patient simulators were created. While role-playing and acting out patient care interventions, staff members were encouraged to work together as a multidisciplinary team and to communicate with the simulated team members. Communication was inherent in the simulations because participants needed to work collaboratively to determine patient needs (Mager et al., 2012).

Ineffective communication and teamwork related to delegation and hand-offs can contribute to adverse events for patients. As the Agency for Healthcare Research and Quality (AHRQ) seeks to improve patient safety at hand-off, simulation has been recognized as one method to enhance the valuable communication skills and teamwork efforts of health care workers (Clancy, 2008). Reported advantages of simulation for research, training, and performance assessment include: no risk to actual patients; allowing diverse scenarios to be presented at will; enabling participants to visualize the results of actions taken and to build communication and teamwork through participation; and providing the opportunity to save scenarios for debriefing or future training (Gaba, 2000). Debriefing is also one of the most important aspects of simulation. Debriefing includes the attributes of active engagement, reflection, emotional release, and openness to feedback (Dreifuerst, 2009). By using realistic, customizable simulation experiences, Mager et al. (2012) argue that participants can ultimately improve their interpersonal teamwork skills and communication.
Cost Analysis

Measures to enhance communication between RNs and PCAs should not incur any actual financial expense, particularly in the short term. Staff members engaged in simulation exercises may or may not be compensated for their time depending on Patient Care Manager approval and/or institutional protocol. However, the long term cost savings with improved RN and PCA communication could amount to greater productivity and reduced staff turnover rates. Climate and communication both affect turnover, but lower turnover is dependent on the interaction between climate and communication. In reward-based administrative climates, higher levels of communication openness and accuracy explain lower turnover of nursing staff, relative to institutions with an ambiguous climate (Anderson, Corazzini, & McDaniel, 2004).

By contrast, poor communication and workplace incivility in health care often results in financial loss and not only adversely impacts the health of employees but also compromises patient safety. Workplace incivility can cost a hospital an estimated $1.2 million annually for direct care staff alone (Hutton & Gates, 2008). Recent studies of the costs of nurse turnover have reported results ranging from about $22,000 to over $64,000 per nurse turnover (Jones, 2005). Turnover costs, in general, have been estimated to range between 0.75 to 2.0 times the salary of the departing individual (McConnell, 1999), while nurse turnover costs have been estimated at 1.3 times the salary of a departing nurse (Jones, 2005). However, these estimates may vary depending upon the human capital, e.g., the education, experience, and tenure of the nurse who leaves; the era during which the nurse departs, e.g., at the beginning versus the height of a nurse shortage; and other organizational and environmental factors, such as the local labor market and whether the organization is in a rural or urban location (Jones & Gates, 2007).
Project Overview

The objective of this project is to develop a video simulation intervention to promote effective communication between RNs and PCAs. Evidence-based literature has suggested that simulation projects using human simulators effectively assessed the ability of nurse-nursing aide teams to integrate best practices and encourage shared decision making and communication (Mager et al., 2012). Initially, RNs and PCAs would be asked to participate in a 7-question survey regarding communication using the 5-point Likert Scale (see Appendices C & D). Once the survey results are analyzed, a specific communication scenario for the simulation would be developed, such as communication during morning hand-off.

Ideally, the unit RNs and PCAs would collaborate and create several filmed simulation scenarios depicting a combination of scripted and improvised dialogue that reflect both effective and ineffective communication relevant to the unit. However, it is important to acknowledge the psychosocial complexities involved in not only producing the simulation videos in-house but also evaluating staff responses to the videos, which may prove challenging given any staff politics these videos and staff actors may trigger. Therefore, in the interest of time and simplicity for the project, it was decided that the pilot video simulation would employ a nurse and nursing student unaffiliated with the hospital unit to minimize staff bias and scheduling conflicts (if unit RNs and PCAs were to actually be used in the simulation). Furthermore, to avoid potential legal liabilities the pilot simulation video would be filmed in a neutral location unaffiliated with the hospital used in this project.

The implementation and subsequent evaluation of the simulation project would occur across a span of approximately four weeks. The first week would entail drafting a script portraying a realistic delegation communication scenario with input from staff RNs and PCAs.
The second week would involve filming the actors with either a smart phone or small camera. The simulation video would run about 4-5 minutes total. Upon completion of filming the simulation, the following two weeks would be devoted to implementing the intervention:

1. Staff RNs and PCAs initially surveyed with the 7-item questionnaire would be asked to view the video simulation on site during their shift or at a Council meeting.
2. A debriefing session would immediately follow, asking the viewer about his or her thoughts and impressions of the content and message of the video.
3. The viewer would then be asked to complete a 3-item post-test survey regarding the simulation and whether the intervention would affect the viewer’s future communication style during delegation and hand-off.

See Appendix B for the Project Timeline.

**Methodology**

In order to first establish a baseline understanding of the current state of RN-PCA communication on this unit, RNs and PCAs were asked to participate in a pre-test 7-question survey using the 5-point Likert Scale format, which graded responses ranging from strongly agree to strongly disagree. (See Appendices C and D.) RNs and PCAs were interviewed in person on the unit during both day and night shifts and usually alone without distraction from fellow staff. The surveys did not occur in the presence of patients or physicians. A total of 24 RNs (n = 24) and 9 PCAs (n = 9) were included in this survey. Both RN and PCA respondents included a diverse mix of ages, races, ethnicities, and cultural backgrounds. Two PCAs refused to partake in the questionnaires for personal reasons (and were thus excluded from the survey results) while all RNs who were approached agreed to be interviewed.

The results of the surveys reflect differences in perception of communication between
RNs and PCAs. When asked if they agreed that communication between RNs and PCAs was effective in the past year, most RNs (45.83%) disagreed while most PCAs (44.44%) did agree that communication had been effective over the past 12 months. Most RNs (58.33%) and PCAs (44.44%) believe that delegation was understood and clearly communicated. There was no real consensus from either RNs or PCAs about whether check-ins was effective. The majority of both RNs and PCAs believed that phones were beneficial to enhance communication. Amongst RNs, one-third felt the PCA-to-patient workload was manageable and one-third disagreed. By contrast, most PCAs (55.55%) believed their workload was manageable. When asked to define the most critical communication challenge(s) between RNs and PCAs, 2/3 of RNs indicated Personality, and over half of the RNs surveyed selected Work Ethic. Similarly, most PCAs (44.44%) chose Personality as the main factor hindering effective communication with RNs. Most RNs and PCAs would choose not to join an in-house Council or Committee to address communication issues. See Appendices E & F for results to the communication surveys.

**Development of Simulation Scenario:** Face-to-face morning communication during hand-off and delegation between an RN and PCA was chosen as the pilot simulation scenario to video record and later implement for post-test evaluation. The goals of creating the pilot simulation scenario is to thoroughly and accurately portray the most critical communication challenges between RNs and PCAs. Each skit will highlight effects of body language, eye contact, tone of voice, and reciprocal dialogue on overall communication. The scenario was created organically from months of casual observation on a medical-surgical unit and input was used from two RNs on the unit and one RN not affiliated with the medical-surgical unit.

**Scenario Title:** Communication between RN and PCA during hand-off/delegation

**Background information:** Shortly after change of shift at 0700, an RN on a medical-surgical floor
touche base with the assigned PCA to confirm plan of care for the RN’s clients for the shift. The RN is reporting an update to the PCA regarding a middle age, incontinent, and mentally challenged client who is status post left hip fracture 24 hours. This particular client has been on the unit multiple times over the past three years for various ailments and the RN and PCA have cared for this client before in the past.

**Learning objectives:**

- Identify best practices in verbal and non-verbal communication between RN and PCA
- Demonstrate collegial communication/reporting/hand-off skills with other staff members

**Ineffective Communication Scenario**

(General script; actual simulation video duration: 1 min 49 sec)

**RN:** *(as PCA is about to enter a patient’s room with towels draped over her arm, RN approaches PCA abruptly without greeting her by name first thing in the morning and avoids direct eye contact while holding her brain)*

Excuse me, excuse me…. hey, we’ve got a really busy morning today. I need you to do vitals on Room 55 first – his blood pressure was a bit unstable last night. As you can probably tell from the smell, he also soiled himself earlier this morning so he needs his diaper changed as soon as possible. Take care of Room 55 first before you do the vital signs for all your other patients, okay? He’s hairy, so remember to thoroughly clean his skin with the chlorhexidine wipes too. Also be sure to chart the vital signs immediately after you take them – yesterday you missed the 1200 vitals for Room 46. You have to be more careful…

**PCA:** *(sighs loudly, rolls eyes, frustrated already by RN’s non-collegial attitude)*

Yesterday it wasn’t my fault that I didn’t take 1200 vitals on Room 46 – I was supposed to be on my break so whoever took the vitals did not do it. Don’t blame me.

**RN:** It was my understanding that you were supposed to do the 1200 vitals on 46. That’s what
the Charge Nurse said. Well whatever, I could be wrong but now is not the time to argue or get defensive. So for Room 55, are you clear about what you need to do?

**PCA:** Look, I will try to take his vitals and change his diaper quickly but I cannot spend that much time on him. I have 10 other patients I need to take vitals on…Maybe you can help me with 55 to change his diaper since he is big…?

**RN:** I’m sure you can handle 55 on your own. We’ve had him as a patient before. Plus he is not that overweight.

**PCA:** *(signs loudly, raises voice slightly, shakes head)* You know what? Whatever… I can’t talk anymore… I have too much to do…! *(turns away abruptly and enters patient room)*

**RN:** Call my phone only it’s urgent...

**Effective Communication Scenario**

*(General script; actual simulation video duration: 2 min 7 sec)*

**RN:** *(Approaches PCA with eye contact and smile)* Good morning Kristin, how are you?

**PCA:** *(Responds with eye contact and smile)* I’m good, thank you. How is your morning?

**RN:** I worked a 12-hour yesterday, so it was hard getting out of bed this morning. But I’m doing fine – looking forward to a 4-day break. Hey, remember Mr. Gavin from 6 weeks ago? Looks like he’s back on the unit for a left hip fracture.

**PCA:** Oh yeah, I remember. Poor Mr. Gavin, he’s been to our unit 3 times already this year!

**RN:** I know! He’s such a sweet guy though. Anyway, according to the shift report, it looks like Mr. Gavin’s blood pressure was dropping a bit low at 0400 and 0600. I better go see him first.

**PCA:** Okay. Didn’t the night nurse say something about a diaper change?

**RN:** Yes, he just had a bowel movement at 0630. So can you…

**PCA:** Oh definitely – I’ll go grab some extra wipes and diapers, just to be safe.
RN: Thanks Kristin. You know, let’s go to Room 55 together. After I am done assessing his blood pressure we can then reposition him and clean him up together – he is more of a two-person assist I think.

PCA: Thank you. I think I can do it on my own but I definitely appreciate your help.

RN: No problem! Hey, we’re a team. So do you have any other questions about your tasks for the day?

PCA: (Looks at PCA sheet) I think I am good for now. I have my phone so I will call you if I need anything from you.

RN: Ok. Sounds good. Maybe we can check in together at 1000.

PCA: Sure – as you know I might be really busy with the vital signs since I have 10 patients but I will remember to call you then.

RN: Thanks Kristin. You’ve always been good about that and I really appreciate it. Ok, see you in Room 55 shortly…

After viewing the video simulation, participants were asked to debrief and share their thoughts and impressions of what they saw. Participants were asked to analyze and discuss whether the communication portrayed in the simulation was appropriate, respectful, and effective. Afterwards, participants were asked to complete a 3-question post-test survey using the 5-point Likert Scale once again to determine the ultimate effect of the video intervention (see Appendix G). Participants were asked how strongly they agree or disagree with the following statements:

- The pilot video simulation effectively and realistically portrays collegial and non-collegial communication between an RN and PCA during delegation and hand-off.
- The video simulation encourages me to reexamine my own communication style and
practice with RNs or PCAs.

• The video simulation project should be adopted by the unit and include more in-house videos in the future that address improvement in communication between RNs and PCAs.

The videos were also uploaded to YouTube for reference:

Ineffective communication: https://www.youtube.com/watch?v=yCQHHkh75us
Effective communication: https://www.youtube.com/watch?v=iIVQHG_v7HU

Results

A total of 8 RNs participated in the intervention across several on-site visits. By contrast, no PCAs were available to commit the amount of time needed to participate in the intervention. Despite the relatively low $n$ value, the survey results indicated that the majority of RNs interviewed strongly believed that the pilot video simulation effectively and realistically portrayed collegial and non-collegial communication. About a third of the participants strongly felt the video encouraged them to reexamine their own communication style and practice with other staff members. Moreover, half of the respondents strongly believed that the video simulation project should be adopted by the unit and expanded to include more scenarios while the other half also agreed that simulation videos should continue to be used to enhance RN-PCA communication. See Appendix H for a summary of the post-test results.

Evaluation

Despite the relatively low $n$ value of the sample size, the results of the video simulation intervention suggested that simulation could be an effective method to help improve communication between RNs and PCAs over time. It was recommended that this video simulation exercise continue over a period of at least twelve months in order to increase the variety of simulation scenarios filmed and ultimately establish a sufficiently large sample size
where the majority of both unit RNs and PCAs would be able to participate in the interventions. In order for this project to succeed, unit-based Patient and Staff Council committees were encouraged to adopt the video simulation exercises are part of their monthly meeting agenda. Initially, Unit Managers would be made aware of the need to notify all staff of this project through emails and incorporate time to implement this project during Council meetings. In addition, the simulation project would greatly benefit from the commitment of a minimum of a floor RN and one PCA from the unit to become champions of the project and help coordinate the simulation exercises. With interdisciplinary collaboration, the simulation can be customized to a particular unit and effectively address the pertinent issues on the unit.

Only when there is commitment from both Staff and Management will the project plan become sustainable in the long term. Ideally, the video simulation project would create a new hypothetical communication scenario each month to be shared and debriefed during the monthly Staff/Council meetings. By the end of the 12-month period, another post-test survey would be distributed unit-wide to further evaluate any changes in the perception of communication between RNs and PCAs.

The difficulty in achieving participation from PCAs also needed to be further explored. Perhaps greater participation from both PCAs and RNs could happen if team leaders embraced the alignment theory of teamwork, such that to accomplish successful teamwork, RNs and PCAs would be assigned consistently to same teams to foster close working relationships (Hayes, 1994). Furthermore, the ability to work as a team outside of scheduled staff hours will be influenced by the extent that RNs and PCAs share equivalent views regarding the definition and provision of safe, quality patient care (Schirm et al., 2000).
Conclusion

Communication between RNs and PCAs is vital to providing safe and quality patient care. It is in the best interest of all units to strive to improve communication and thus teamwork. As evidenced by this project and evidence-based practice, simulation is also proven to be an effective method to assist healthcare team members to improve their skills and communication habits. It is therefore in the best interest of all units to invest in Unit Council committees to provide the opportunity and time (and possibly compensation) necessary to develop video simulation as an integral part of any unit improvement initiative.
References


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Appendix A

Root Cause Analysis For Enhancing RN-PCA Communication

- **RN**
  - Insufficient check-in with PCA
  - Mistrust of PCA
  - Failure to anticipate patient/PCA needs
  - Excess or inadequate delegation to PCA
  - RN Personality
  - Poor work ethic

- **PCA**
  - High patient load
  - Insufficient check-in with RN
  - Language barrier
  - Failure to anticipate patient/RN needs
  - PCA Personality
  - Poor work ethic
  - Lack of sense of work ownership
  - Job resentment

- **Staff Education**
  - Lack of awareness of job expectations
  - Inadequate training
  - Lack of interpreters
  - Inconsistent communication between manager and staff

- **Methods**
  - Inconsistent hourly rounding
  - Lack of SBAR communication
  - Ineffective teaching or training
  - Poor management feedback
  - Underutilization of telephones
  - Lack of email responses

- **Patient**
  - Unmet needs
  - Feels guilty to use call light
  - Language barrier with staff
  - Cultural differences with staff
  - Personality conflict with staff
  - Mistrust of staff

- **Ineffective communication between RN and PCA, ultimately jeopardizing quality and safety of patient care**
Appendix B – Project Timeline

Week 1-2
- Conduct Unit Microsystem Assessment
- Create communication board
- Meet with Nurse Manager, Assistant Nurse Manager, and Preceptor

Week 3-4
- Select Topic based on Microsystem assessment: Enhancing RN-PCA communication
- Develop Root Cause Analysis
- Conduct literature review
- Determine approach and timeline

Week 5-7
- Develop specific questionnaire to explore chosen topic
- Conduct pre-test RN and PCA questionnaires - both day and night shifts
- Observe communication hand-off and delegation between RNs and PCAs on unit

Week 8-9
- Refine and specify project topic: Using video simulation to enhance RN-PCA communication
- Develop potential simulation scenarios
- October 28, 2014: Attend monthly Patient Council Meeting; present project to team

Week 10-11
- November 4, 2014: Present project to monthly Staff Meeting
- Develop simulation script
- Assemble simulation team (one RN, one PCA)
- Film simulation video; upload to YouTube

Week 12-15
- Implement video simulation project: play videos, debrief, and conduct post-test surveys with RNs and PCAs who participated in pre-test surveys
- Evaluate progress and present findings to Assistant Nurse Manager and unit
- Complete CNL project report and poster board
Appendix C

RN Survey

1. Communication between RNs and PCAs has been effective within the past 12 months.
   Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree

2. PCAs clearly understand the specific tasks that are expected of them.
   Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree

3. PCAs frequently check in with me to address patient care issues.
   Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree

4. The phones have been an effective and reliable method to communicate with the PCAs.
   Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree

5. The PCA-to-patient ratio is manageable on the unit.
   Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree

6. The most critical communication challenge(s) between RNs and PCAs is due to:
   - Lack of awareness of job expectations from PCAs
   - Inadequate training of PCAs
   - Insufficient check-ins/rounding
   - Personality
   - Work Ethic
   - Other________________________________________

7. Would you be interested in participating in a council meeting to help improve communication between RNs and PCAs?
   YES   NO
Appendix D

PCA Survey

1. Communication with the RNs has been effective over the past 12 months.
   - Strongly Agree
   - Agree
   - Neutral
   - Disagree
   - Strongly Disagree

2. RNs clearly describe the tasks that they delegate to me.
   - Strongly Agree
   - Agree
   - Neutral
   - Disagree
   - Strongly Disagree

3. RNs frequently check in with me to address patient care issues.
   - Strongly Agree
   - Agree
   - Neutral
   - Disagree
   - Strongly Disagree

4. The phones have been an effective and reliable method to communicate with the RNs.
   - Strongly Agree
   - Agree
   - Neutral
   - Disagree
   - Strongly Disagree

5. The PCA-to-patient ratio is manageable on the unit.
   - Strongly Agree
   - Agree
   - Neutral
   - Disagree
   - Strongly Disagree

6. The most critical communication challenge(s) between PCAs and RNs is due to:
   - Unclear expectations from RNs
   - Excessive workload
   - Insufficient check-ins/rounding
   - Personality
   - Work Ethic
   - Other

7. Would you be interested in participating in council meetings to help improve communication between RNs and PCAs?
   - YES
   - NO
Appendix E

Results from Pre-Test RN Survey ($n = 24$ RNs):

Communication between RNs and PCAs has been effective within the past 12 months (below left).

PCAs clearly understand the specific tasks that are expected of them (above right).

PCAs frequently check in with me to address patient care issues (below left).

The phones have been an effective and reliable method to communicate with the PCAs (above right).

The PCA-to-patient ratio is manageable (below left).

Would you be interested in participating in a unit council meeting to improve communication? (above right)

The most critical communication challenge(s) between RNs and PCAs is due to (below; Y-axis reflects percentage of respondents who chose factor):
Appendix F

Results from Pre-Test PCA Survey (n = 9 PCAs):

Communication with the RNs has been effective over the past 12 months (below left):

- RNs clearly describe the tasks that they delegate to me (above right):
- RNs frequently check in with me to address patient care issues (below left):

The phones have been an effective and reliable method to communicate with the RNs (above right):

The PCA-to-patient ratio is manageable (below left):

Would you be interested in participating in a unit council meeting to help improve communication (above right):

The most critical communication challenge(s) between RNs and PCAs is due to (below; Y-axis reflects percentage of respondents who chose factor):
Appendix G

RN and PCA Post-Test Survey After Viewing Simulation Video:

1. The pilot video simulation effectively and realistically portrays collegial and non-collegial communication between an RN and PCA during delegation and hand-off.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

2. The video simulation encourages me to reexamine my own communication style and practice with RNs or PCAs.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

3. The video simulation project should be adopted by the unit and include more in-house videos in the future that address improvement in communication between RNs and PCAs.

<table>
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<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>
Appendix H

Results of Post-Test Survey (n = 8 RNs, 0 PCAs):

The pilot video simulation effectively and realistically portrays collegial and non-collegial communication between an RN and PCA during delegation and hand-off:

The video simulation encourages me to reexamine my own communication style and practice with RNs and PCAs:

The video simulation project should be adopted by the unit and expanded to include more scenarios in the future that address improvement in communication between RNs and PCAs: