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Improving the Use of the Integrative Healing Approach

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Abstract

The Integrative Healing Approach (IHA) is an initiative that promotes holistic healing and includes the use of essential oils, deep breathing techniques, and therapeutic touch. Its purpose is to relieve pain, anxiety, insomnia, and depression among patients, and stress among staff. The IHA pilot initiative was implemented on the Acute Rehabilitation Unit (ARU) and faced barriers to implementation after the first round of staff education. By rounding with staff and conducting surveys, it was identified that the staff are not using IHA interventions as often due to time constraints. Additionally, there is an identifiable rift between Registered Nurses (RNs) and Certified Nursing Assistants (CNAs) which has affected the culture of the unit, making it difficult for RNs and CNAs to communicate regarding IHA interventions, thus decreasing IHA use. The aim of the Clinical Nurse Leader (CNL) is to directly improve the culture of the ARU by developing a comprehensive IHA patient assessment tool and IHA resource sheets to improve patient satisfaction along with engagement of staff. Upon interviewing, RNs stated that the new IHA patient assessment tool was easy to use. 50% of CNAs reported that they now had an adequate amount of time to use IHA interventions, an increase from 20%. The majority RNs and CNAs found the available resources helpful and used the resources often. The CNAs play an important role in the care of patients and are highly motivated. With clear communication from the RN, the CNA has the potential to impact the use of IHA interventions.

Introduction

The Integrative Healing Approach (IHA) was first introduced to the ARU in October of 2017. As a new initiative, it was met with both excitement and hesitation. IHA has been shown by countless studies to not only improve the patient outcomes of those dealing with anxiety,

pain, and emotions, but also to mitigate the stress of staff. IHA interventions are a holistic healing approach that include use of essential oils, deep breathing techniques, therapeutic touch, and meditation.

Problem Description

With the implementation of IHA, management's goal is to provide staff with the tools to manage patient stress and anxiety along with their own stress and anxiety. Staff were educated in either one day classes or a three-day mentor class by an outside consultant. Three months after implementation, rounding with staff and patients show that many staff, including CNAs, are meeting barriers to implementation. Staff expressed the concern that there is not enough time to use their IHA skills and they were often met with patients who were allergic to the oils or did not want to participate. In general, integrative health initiatives can often be met with resistance after the first round of implementation due to its stark differences to that of western medicine. In contrast to a traditional medication regimen as is seen in Western Medicine, integrative health focuses on typical Eastern medicinal practices which promote patient self-reflection to further their healing. Furthermore, after assessing data and interviewing staff, it became apparent that CNAs on the unit feel as though they are not respected or empowered.

Based on the 2017 data survey, "The Caregiver Experience Survey," nursing assistants and aids who reported that they were "willing to put in a great deal of effort beyond what is normally expected to help my organization succeed" increased by 10% from the previous year. Because CNAs spend most of their shift with their patients and are highly motivated, they have the potential to make an impact on how often IHA interventions are used. After rounding with multiple CNAs, it was clear that there is a significant rift between RNs and CNAs in which CNAs feel disrespected and communication can be unclear. To use the IHA practice, the RN

needs to effectively communicate with the CNA after assessing the patient and implementing the

IHA plan of care. The CNAs who have limited communication with the RN face a barrier for

IHA implementation. A Root Cause Analysis (Appendix A) and a Fishbone Diagram (Appendix

B) were utilized and identified the need for a clear IHA patient assessment tool and additional

resources pertaining to IHA use.

Available Knowledge/Literature Review

The following PICO statement was used to develop keywords for my literature search:

"Does education promoting interdisciplinary communication between CNAs and other staff

compared to IHA re-education improve CNA engagement and patient outcomes?" I then used

keywords such as "certified nursing assistant," "integrative health," "staff engagement," and

"communication" to search databases for my population of interest, certified nursing assistant.

My intervention, education promoting interdisciplinary communication, was searched to research

my anticipated outcome of improved CNA use of IHA.

As holistic nursing and complementary and alternative modalities become more prevalent

in hospitals across the nation, it is important to study the effects that holistic nurses see directly

in their careers. A study by Sharoff (2008) explored holistic nurses' experiences through incident

reports and interviews. Thirteen nursing volunteers identified personal and professional growth

and development along with positive patient outcomes as reasons for incorporating holistic

nursing into their practice. Motivation for the practice was described as a need for personal

development and a need for a solution to personal burnout from nursing. Participants noted that

the benefits of a holistic approach to nursing transcend multiple levels of healing, sometimes

filling in the gaps in their nursing practice to provide support, pain relief, and comfort. This

study identified that caring for oneself is as much an important aspect of nursing care, as it is a

prerequisite to helping others. Holistic nursing allows the nurse to practice self-care while finding a connection with his or her patient (Sharoff, 2008).

A study that focused on the perceptions of registered nurses regarding holistic care found that after implementing focus groups with 17 nurses, five themes emerged. These included the following: (a) a benefit to the patient, (b) a benefit to the nurse, (c) holism beyond task orientation, (d) integrating holistic care into acute care, and (e) barriers and challenges. Nurses reported that using holistic care relieved pain, decreased anxiety, and calmed agitated patients. Nurses who completed the training described the benefits to themselves including self-care such as relaxation and the ability to better cope with job related stress. Additionally, nurses reported that using holistic care allowed them to provide nursing care without a task-orientated delivery of care, allowing them to interact and be present with their patients (Anderson et al., 2016).

The same study identified some of the more prevalent barriers including a shortage of time, balancing other nursing priorities, and potential resistance from other staff who are not educated on holistic care. The study suggested that for sustainment, there must be adequate resources which support education and expansion of programs along with an environment that is open and receptive to complementary and alternative medicine (CAM) modalities. It is also suggested that staff who are interested in holistic care can provide support and encouragement to others in monthly practice group sessions and meetings (Anderson et al., 2016).

Perceptions of CNAs' identity at work and the roles that they played in the microsystem were studied by Gray and Lukyanova (2017). After assessing 45 CNAs, the participants identified four roles including connector, advocate, overloaded worker, and companion. Based on this analysis, CNAs work to help the unit run more cohesively, relaying information to managers and have a sense of input on the unit. Their input is usually highly regarded, and

patients feel as though they can trust them. CNAs also expressed their limited decision-making power and feeling disrespected in certain situations. The study suggests making CNAs feel more included by giving them the opportunity to participate in patient care conferences. The study proposes providing CNAs with organizational resources and implementing policies which allow the CNA to be more involved with the RN when planning patient care (Gray & Lukyanova, 2017).

Looking specifically at CNAs, it is a common perception that CNAs are close to their patients, spending a fair amount of their work day with their patient. As a result, CNAs who implement the IHA practice have the potential to make a significant impact on their patient. In a study by Pfefferle and Weinberg (2009), CNA's meaning of care was studied, and CNAs identified the meaning of their work as representing "good work," "God's work," developing a "closeness to residents," and "caring for those who cannot care for themselves." CNAs described their attachment to residents, often depicting them as adopted family or friends and provided CNAs with a motivation to provide care. CNAs participating in this study reported negative messages from managers, supervisor, coworkers, and residents about the value of their work. It was found that the way in which CNAs described their meaning of work defended them against negative feedback. The study suggested that to protect caregivers, organizational structures need to be realigned to include caregivers in the decision-making process. Because caregivers are so involved with patient care, the value of their work needs to be supported and their specialized knowledge about the patient needs to be validated (Pfefferle & Weinberg, 2009). By including CNAs in the IHA program, CNAs have the potential to both impact the patient and change the dynamic between CNAs and other staff.

A study by Ernst & Ferrer (2009), reflected upon a seven-year integrative care program and searched for ways to sustain such a program. The study identified common barriers such as shifting from a medical model to a holistic philosophy, unclear roles within the staff community, lack of knowledge of CAM therapies, and competition for financial support and general funding. The study reflected on changes they made including involving high-level administrators, hiring an advanced practice holistic RN, designating new staff with work responsibilities only for the new program, and allowing staff to attend educational offerings. The most useful approaches mentioned were sitting with the patient and discussing the needs of the individual patient with no mandatory participation, focusing on the process of caring (Ernst & Ferrer, 2009).

A study by Kligler et al. (2011) examined the cost savings associated with inpatient integrative medicine. Cost savings were mainly due to reduced medication use and reduced recovery time for patients. Interventions studied included nutrition, music therapy, and mind-body interventions. Interventions to implement an integrative healing approach included remodeling of the physical space to include a patient lounge for meditation, yoga, and visiting. Additionally, nursing staff were trained on holistic practice with a series of workshops. Yoga therapists and a patient navigator were hired. The study was able to observe a significant decrease in medication costs compared to the control group, averaging $469 per patient in savings. Total savings to the hospital annually would be $977,184. If half of the patients chose to utilize the integrative approach, cost savings would amount to $488,592, annually. Total costs for the program included the start-up costs for upgrading the location and staff training, amounting to $355,000. Ongoing costs for the salary of the patient navigator and yoga coordinator came to $209,000 per year. The study advocated for implementing integrative health programs like their own because they have the potential to significantly reduce the need for

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medication to treat anxiety, insomnia, nausea, and pain. Reduced costs for these medications can create significant cost savings for hospitals (Kligler et al., 2011).

Rationale

To implement the new IHA patient assessment tool, Lippitt's theory of planned change (see Appendix C) was used. Developed in 1968 by Lippitt, Watson, and Westley, this theory is a seven-step plan designed to implement change and is focused on describing the responsibilities of the change agent (as cited in Kritsonis, 2005). This theory of change uses four fundamental ideas to implement change consisting of assessment, planning, implementation, and evaluation. Incorporated in this theory is the well-known Lewin's change model which describes change as first unfreezing (assessing what the change will be), moving (implementing the change), and then refreezing (establishing the change and finalizing it) (Mitchell, 2013).

Phase 1, diagnosing the problem, was addressed after the initial IHA classes had been taught, and there was still resistance to the new plan when rounding with staff. Phase 2, assessing motivation and capacity for change, was determined during the data collection process when CNAs were surveyed and interviewed. Surveys showed that CNAs were willing to put in extra effort to see the unit succeed and were invested in the IHA initiative. Phase 3, assessing the change agent, was determined when the CNL student and the IHA mentors on the unit expressed interest in developing a change. Phase 4, selecting progressive change object, occurred when a new assessment tool was determined to be a valuable asset with the potential to provide CNAs with useful resources. Phase 5, choosing appropriate role of the change agent, was demonstrated when mentors agreed to use the tool and educate other staff. Phase 6, maintain change, occurred for a one-month period after implementation and was then re-evaluated. Phase 7, terminating the helping relationship, occurred when the CNL student finished the project.

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Specific Project Aim

The purpose of the Integrative Healing Approach (IHA) assessment tool for RNs is to improve communication between RNs and CNAs, thus increasing the rate at which IHA is used and to improve the morale of staff on the unit, specifically CNAs. The goal of this initiative is to have 75% of CNAs show improvement in IHA intervention use as evidenced by surveys and rounding, in addition to improving the relationship between RNs and CNAs.

Methods

Context

As with any leader, a CNL's responsibility is to continually assess and implement changes to improve functionality of the unit, and more specifically improve patient care. One role of the CNL involves quality improvement and safety. After analyzing information and contributions from differing perspectives of inter-professional healthcare teams, the CNL will be able to use evidence-based research to implement a change strategy, assess how the change is affecting outcomes, and then make the necessary adjustments. The CNL can perform this process utilizing different CNL competencies such as "promoting a culture of continuous quality improvement within a system," "demonstrating professional and effective communication skills, including verbal, non-verbal, written, and virtual abilities," and "lead change initiatives to decrease or eliminate discrepancies between actual practices and identified standards of care" (AACN, 2013).

The 5 P's of a microsystem assessment, including purpose, patients, professionals, processes, and patterns, are all key elements of a microsystem that work together to form a functioning microsystem. The ARU focuses on allowing patients from more acute units to

rehabilitate with the assistance of physiatrists, nursing staff, physical therapists, occupational therapists, speech therapists, and dieticians to obtain the goal of independent function before being discharged. The most common diagnoses on the unit are stroke, traumatic/non-traumatic brain injury, traumatic/non-traumatic spinal cord injury, and lower extremity amputation. The average length of stay on the unit is 13.7 days, considerably longer than most units. 84.2% of patients are discharged to a community setting, 10.9% are discharged back to an acute care setting, and 5.0% are discharged to a long-term care setting or skilled nursing facility. To be a candidate for care, patients must be able to participate in 3 hours of rehabilitation per day, 5 days per week, and must require 24-hour nursing care and daily physician visits.

Because of the unique nature of the unit, nurses on the unit work closely with therapists, often planning patient-care on an interdisciplinary level. Staff huddles are held every Monday and Thursday morning to discuss the current progress of each patient with the nurses, therapists, and physician. More extensive meetings to discuss the plan of care for patients happens once per month with additional attendance by the dietician and social worker. Staff meetings for both the RNs and CNAs are held monthly along with a Shared Governance meeting in which staff volunteers meet to discuss how to improve the unit.

After conducting a SWOT analysis (Appendix D) for the unit, strengths found for the unit include CNAs reporting that they are willing to put a great deal of effort beyond what is expected of them, 32% of both RNs and CNAs are highly engaged, and 44% of CNAs are highly engaged. Weaknesses of the unit include a reported communication barrier between RNs and CNAs. CNAs report not feeling empowered, data shows low patient satisfaction scores, and 42% report feeling detached. Opportunities for the unit include a need to provide stress relief to patients and staff and additional benefits of IHA such as faster healing times and decreased length of stay.

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Other opportunities include the benefit of support for the IHA program from both the community and administration. Threats include possible budget cuts from administration and a changing attitude towards to IHA.

As of January 2018, all nursing staff on the unit had been educated on IHA. Nurses and CNAs who showed interest were invited to participate in 3-day course and took on the role as a unit mentor. These mentors are responsible for providing resources to other staff about IHA and advocating for IHA use with both patients and staff. In February of 2018, IHA rounding took place to identify areas that needed improvement. The IHA consultant determined that frequent rounding and encouraging mentors to continue using IHA would be the most beneficial for sustainment.

In terms of financial savings (Appendix E), the cost of the IHA patient assessment tool implementation was compared with the potential cost to educate the staff for a second time. Based on the "FTE and Wages" data from the 2018 budget, the wage impact to educate 11 staff for a 3-day class, 35 staff for a 2-day class, and 26 staff for a 1-day class amounts to $38,494. The cost to pay a private instructor ($125 per hour), an assistant instructor ($80 per hour), administration support costs, and catering for the 3-day classes amounts to $13,869. The proposed alternative to a second round of teaching includes a CNL working as a unit mentor rounding 4 hours per week with staff and patients ($80 per hour), the CNL attending the Unit Based Council for 8 hours per month ($80 per hour), the CNL attending staff meetings for 8 hours per month ($80 per hour), and the CNL spending 8 hours per week planning and processing an improvement plan. The total expense for a CNL to take on this role amounts to $16,320 for a three-month period. Total savings by using a CNL to take on the role of a unit

mentor and initiate the process improvement plan as opposed to re-educating the unit with a private instructor amounts to $36,043.

Intervention

The intervention for this quality improvement project is a new IHA patient assessment tool that will provide RNs with a clear understanding of how to initiate IHA interventions and which treatment plan to follow, encouraging clear communication with the CNA. The timeline that demonstrates implementation of the project is shown in Appendix F. The tool includes clear instructions that prompt the RN to assess the patient for problems which qualify the patient for IHA interventions. Additionally, IHA resource sheets were created for each diagnosis such as pain, anxiety, or insomnia and the most common IHA practices to use for each. Including a resource page with interventions for each diagnosis will help RNs and CNAs use the IHA interventions in a time-efficient manner instead of spending time searching through reference pages to find the right intervention. The IHA patient assessment tool was placed in the "Discharge Process Checklist" binder for each patient, and resources were laminated and made available in the nursing station. Additionally, the IHA patient assessment tool was hung up on the IHA white board to draw the attention of staff. After the tool was implemented for one month, the tool was evaluated, and changes were made.

Study of the Intervention

After one month of implementation of the tool, evaluation of the tool itself was completed by individually interviewing staff about the tool. Staff recommended the assessment tool be condensed to one page and recommended an announcement be sent to all staff. IHA

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mentors on the unit were also individually interviewed with their specific input. With new

suggestions from staff, the nurse manager, and unit mentors, changes to the tool were made.

Measures

In February, surveys were handed out to CNAs addressing the level of interest in IHA

and how often IHA is used. CNAs individually addressed barriers to use such as time constraints

and communication with RNs. An assessment tool was implemented in March and an evaluation

occurred one month later in April. After the first assessment, changes to the tool were made. The

implementation of the new assessment tool is part of the planning and processing step for the

CNL. Surveys measuring how often CNAs use IHA along with the staff's perception of the

resources were handed out and compared to the initial data. Staff were also interviewed

concerning the final assessment tool and if the resource sheets were frequently utilized.

Results

Upon interviewing, RNs stated that the IHA patient assessment tool was clear, easy to

use, and the one-page format was helpful. Additionally, unit mentors stated that staff were using

the resource sheets often. After surveying, 50% of CNAs reported that they had an adequate

amount of time to use IHA interventions, which showed an increase from 20%. Additionally,

78% of RNs surveyed found the resources available helpful and 67% used the resources multiple

times a shift or once a shift. 100% of CNAs surveyed found the resources helpful and 50% of

CNAs used the resources multiple times a shift or once a shift. Data regarding IHA use by CNAs

before and after implementation was inconclusive, suggesting the tool needs more

implementation time and evaluation. Furthermore, a handful of RNs surveyed expressed the need

for further IHA education.

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Discussion

Summary

As the data shows, CNAs on the ARU are motivated, engaged, and willing to use IHA interventions in their practice. As a group, they identify as hard-workers and believe that IHA interventions make a difference in patient care. As evidenced by anecdotal evidence along with observation, there is a communication barrier between RNs and CNAs which has limited IHA use. For CNAs to implement IHA interventions, the RN must initiate the IHA care plan after assessing the patient, and then must relay the order to the CNA. Due to the communication barrier between RNs and CNAs, the IHA orders are not always clear for the CNAs. The aim of the IHA patient assessment tool is to facilitate communication between the RN and CNA and make it easier for CNAs to use IHA interventions.

The results of the implementation showed that RNs are happy with the improved IHA patient assessment tool and staff members are using the resources available. Additionally, CNAs who feel as though they have enough time to use IHA interventions increased from 20% to 50%. Data showing increased use of IHA interventions by CNAs was inconclusive, and follow-up of the implementation is still needed. Changing the culture of the unit to one which promotes a healthy relationship between RNs and CNAs is a long and difficult task that will take time. Ideally, the new IHA patient assessment tool will continue to be used and changes will be made as necessary. Because the CNAs on the ARU are willing to improve the organization and because CNAs spend most of their shifts providing direct patient care, they have potential to improve the use of IHA interventions. Further recommendations for the unit include evaluating and changing the tool as needed, encouraging CNAs to take action on IHA use, and working on

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improving the relationship between RNs and CNAs. Moreover, a few RNs identified the need

for more IHA education, which is something the ARU could consider for the future.

Conclusion

In conclusion, while the goal of increased IHA use by CNAs was not met in full, staff

expressed interest in the revised IHA patient assessment tool and IHA resource sheets. With use

of the new IHA assessment tool, RNs and CNAs can communicate and work together to provide

effective patient care. CNAs continue to play a vital role on the ARU and with a change in

communication, can utilize their motivation and potential to encourage IHA use on the unit and

improve patient outcomes.

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Appendix A

Root Cause Analysis

```
┌─────────────────────────────┐
│ RNs and CNAs are not using  │
│ IHA interventions           │
└─────────────────────────────┘
              │  [Why?]
              ▼
┌─────────────────────────────┐          ┌──────────────────────────────┐
│          No Time            │ ───────▶ │ No Clear and Easy-to-Use     │
│                             │          │ Resources                    │
└─────────────────────────────┘          └──────────────────────────────┘
              │  [Why?]                                │  [Solution]
              ▼                                        ▼
┌─────────────────────────────┐          ┌──────────────────────────────┐
│ RN/CNA communication is not │          │ New Easy-to-Use Resources    │
│ efficient                   │          │                              │
└─────────────────────────────┘          └──────────────────────────────┘
              │  [Why?]
              ▼
┌─────────────────────────────┐
│ No clear and concise way to │
│ communicate IHA             │
│ implementation              │
└─────────────────────────────┘
              │  [Solution]
              ▼
┌─────────────────────────────┐
│ Improved Assessment Tool    │
└─────────────────────────────┘
```
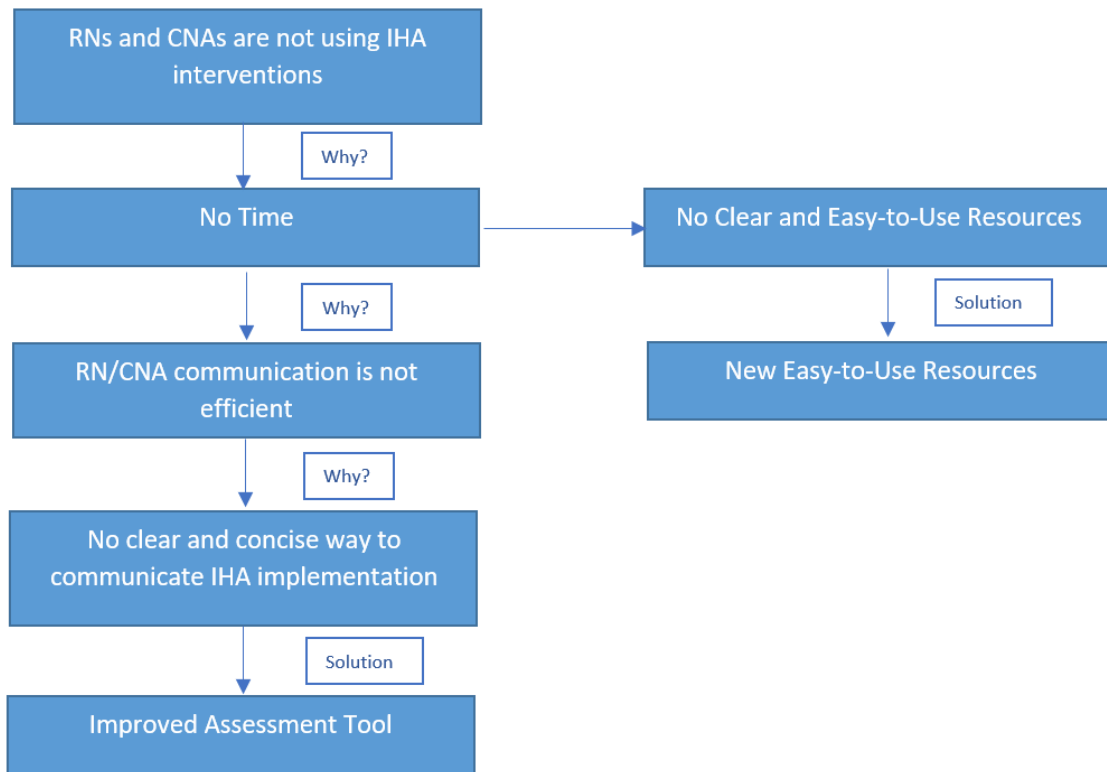
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Appendix B

Fishbone Diagram

People

Patients are not educated on what IHA is.

Patients are not comfortable with IHA.

CNAs need an RN assessment before CNAs can do an intervention.

Environment

High Stress Environment.

CNAs do not feel Included.

Rift between RNs and CNAs.

Staff are not using IHA interventions.

Patients are allergic to oils.

CNAs report there is not enough time to use IHA.

Tools for CNAs to use are not available.

No clear assessment tools.

Concise resources are not available.

Materials

Methods

Equipment

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Appendix C

Lippitt's Theory of Change

Lewin's Change Model	Lippitt's Theory of Change
	Phase 1: Diagnose the problem
Unfreezing	Phase 2: Assess motivation and capacity for change.
	Phase 3: Assess change agent's motivation and resources.
Moving	Phase 4: Select progressive change objective.
	Phase 5: Choose appropriate role of the change agent.
Refreezing	Phase 6: Maintain change.
	Phase 7: Terminate the helping relationship.

(Mitchell, 2013)

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Appendix D

SWOT Analysisrift

Strengths

-RN's are proud to work for their organization.
-CNAs are willing to put a great deal of effort beyond what is expected of them.
-32% of staff are highly engaged.
- 44% of CNAs are highly engaged.
-CNLs and leaders of the unit are present.

Weaknesses

-Rift between RNs and CNAs.
-CNAs do not feel empowered.
-Patient satisfaction is low.
-42% of staff are detached.
-37% of RNs are detached.

Threats

-Financial support from administration.
-Budget cuts.
-Changing attitude towards IHA, disinterest.
-Rift between RNs and CNAs.

Opportunities

-A need to provide stress relief to patients and staff.
-Support from community benefits.
-Support from administration.
-Opportuinty to fix rift between staff.

Appendix E

Financial Analysis

Re-Education Costs	
FTE and Wages 2018 Budget	
11 staff 3-day class	
35 staff 2-day class	
26 staff 1-day class	
Total	**$38,494**
Education Costs	
Private Instructor at $125/hr	$8,000
Assistant Instructor at $80/hr	$5,120
Administration Support Costs and Catering	$449
Total	**$13,869**
Total Expense	**$52,363**

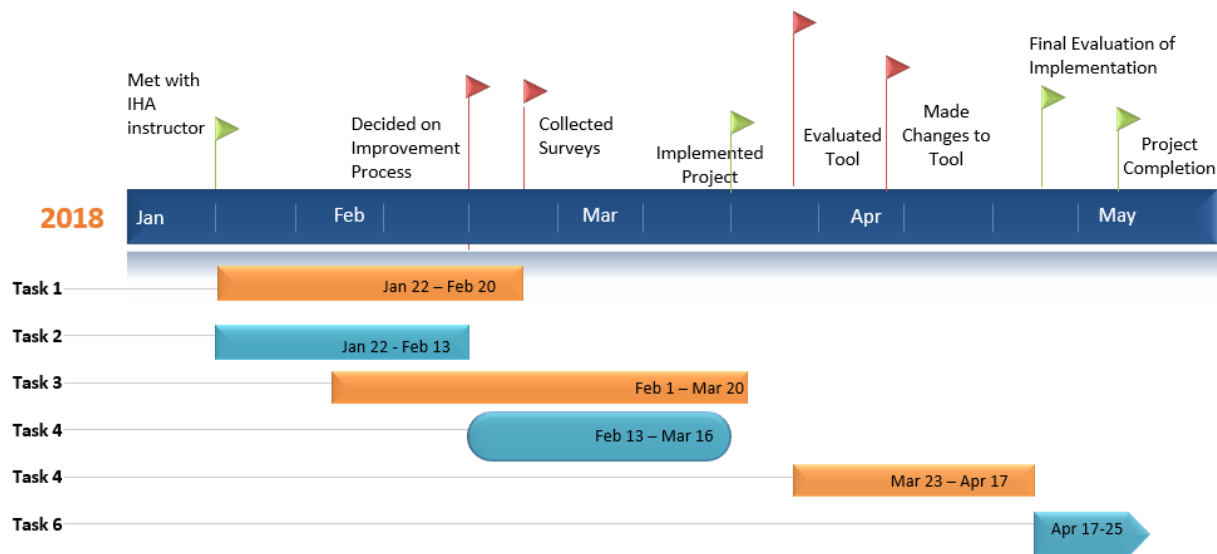| Proposed Alternative to Re-Education (12 Weeks)	
Unit Mentor/CNL Salary	
Rounding with Staff and Patients (4 hrs per week) $80/hr:	$4,160
Attending Unit Based Council (8 hours per month) $80/hr	$1,920
Attending Staff Meetings (8 hours per month) $80/hr	$1,920
Planning Improvement Plan (8 hours per week) $80/hr	$8,320
Total Expense	**$16,320**

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Cost Benefit Analysis	
Reduction in Costs	$52,363 - $16,320 = **$36,043**
CNL Program Cost	**$16,320**
CBA Ratio	$36,043/ $16,320 = **2.2**

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Appendix F

Project Timeline

IHA Assessment Tool Timeline

Met with IHA instructor

Decided on Improvement Process

Collected Surveys

Implemented Project

Evaluated Tool

Made Changes to Tool

Final Evaluation of Implementation

Project Completion

2018   Jan   Feb   Mar   Apr   May

Task 1 — Jan 22 – Feb 20

Task 2 — Jan 22 - Feb 13

Task 3 — Feb 1 – Mar 20

Task 4 — Feb 13 – Mar 16

Task 4 — Mar 23 – Apr 17

Task 6 — Apr 17-25

Task 1: Collecting Data
Task 2: Formulating Project Idea
Task 3: Research
Task 4: Creating Assessment Tool
Task 5: Assessing and Revising Assessment Tool
Task 6: Project Evaluation