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# Improving Nursing Communication Outcomes Through the Tell-Us Card

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Improving Nursing Communication Outcomes Through the Tell-Us Card

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## Abstract

Nursing communication plays a pivotal role in patient-centered care. However, statistics have shown that failures in communication exist in more than 20% of all hospital settings (Sethi & Rani, 2017). Within the explored microsystem, a gap in patient communication was identified through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys. Reports revealed that the microsystem was performing at 69%, which is 11% below the national average for nursing communication (Centers for Medicare and Medicaid Services [CMS], 2018). After performing a microsystem assessment, there was a measurable communication opportunity between the patients and nurses. It was determined that this area of improvement in communication could be enhanced through the Tell-Us Card (Jangland, Carlsson, Lundgren, & Grunningberg, 2012). Proper communication between patients not only addresses the patient's communication needs but can also be used as a tool to prevent adverse events as patients have more autonomy and are more knowledgeable about their care. This intervention was introduced to the staff within the microsystem and is currently being implemented. Within a six-month period, it is predicted that HCAHPS survey scores will increase as a result of improved nurse-to-patient communication through the Tell-Us Card.

*Keywords:* communication, HCAHPS, nurse, patient, satisfaction, patient-centered care, Tell-Us Card, communication tool

### Improving Nursing Communication Outcomes Through the Tell-Us Card

Communication is defined as the act of conveying information through an exchange between two parties. The process is cycled until the speaker's messages have been successfully expressed and understood by the receiver (Institute for Healthcare Improvement [IHI], 2018). In the context of patient care, communication is demonstrated when information delivered by the patient is received by the interprofessional team and then integrated into the patient's care. When patients understand information from their care team, they are propelled to actively participate in their care (King & Gerard, 2013). The Institute for Healthcare Improvement (IHI) identifies this exchange as the cornerstone of interpersonal relationships and an essential component of quality patient-centered care (Joint Commission, 2010). Members of the care team rely on communication to gather important details about their patients to provide high-quality person-focused nursing care that supports patients and families during hospitalization (Cossette, Cara, Ricard, & Pepin, 2005). Patients also rely on communication as a means of gaining access to important aspects of their care. This exchange between nurses and patients influences patient satisfaction and the way patients perceive the quality of their care (Jangland, Carlsson, Lundgren, & Gunningberg, 2012).

Unfortunately, communication gaps exist in more than 20% of all hospital settings (Sethi & Rani, 2017). Most of these barriers stem from within the nurse-to-patient relationship (Jangland, Gunningberg, & Carlsson, 2009). Patient variables such as social customs and language barriers, along with systematic variables such as fragmentation and imbalanced workloads influence the way information is exchanged (King & Gerard, 2013; Carayon & Gurses, 2008). These barriers position patients for poor participation, decreased patient autonomy, fractured interdisciplinary teamwork, medical errors, and patient injuries (King &

Gerard, 2013; Angel & Frederiksen, 2015; Joint Commission, 2010). In fact, the Institute of Medicine (IOM) reported that communication is among the leading causes of patient harm (Institute of Medicine [IOM], 2010; Sehgal et al., 2008). It is for this reason that the Agency for Healthcare Research and Quality (AHRQ) (2011) within the Department of Health and Human Services (DHHS) developed an initiative to encourage engagement between patients and providers through communication. The initiative purported that effective communication led to safer quality care delivery methods and a potential cost savings through a reduction of medical errors (Agency for Healthcare Research and Quality [AHRQ], 2011; King & Gerard, 2013).

The quality and effectiveness of nursing communication is measured by a patient satisfaction tool designed by the Centers for Medicare and Medicaid Services (CMS) called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The survey is required for all hospitals in the United States (U.S.) as it identifies the patient's experiences and encounters with the hospital in several key care delivery areas such as nursing communication (Centers for Medicare and Medicaid Services [CMS], 2017). According to the HCAHPS survey responses drawn from October 2016 through September 2017, the national average for nursing communication was at 80%, whereas, the focused acute care hospital was at 76% and the specific microsystem within this hospital was at 69% (CMS, 2018; Patient Experience of Care Survey Results, 2016). The survey reported that 69% of survey respondents (i.e. patients and/or patient representatives) in the microsystem believed that nurses "always" communicated well during their hospital stay and 31% of patients did not perceive this to be true – indicating room for improvement.

Past healthcare leaders have attempted to address communication issue by developing tools such as the daily goal form, team training, multidisciplinary structured work-shift

evaluation, and communication card (Wang, Wan, Lin, Zhou, & Shang, 2018). Considering the medical-surgical patient population within the microsystem, the proposed change will build upon these proposals by expanding the use of patient-driven communication cards called the Tell-Us Card (Jangland, Carlsson, Lundgren, & Grunningberg, 2012). Implementing this change will help patients to express their needs during their hospitalization and improve HCAHPS survey scores. It will also facilitate an open dialogue between the care teams and patients to promote a culture of person-focused care. As such, the aims of the quality improvement project will be to enhance the patient's experience focusing on nursing communication and – thereby – increase HCAHPS survey scores on nursing communication.

Clinical Nurse Leaders (CNL) are positioned well to address quality improvement initiatives in nursing communication. As noted by King and Gerard (2013), CNLs function as conduits of clear, concise, and effective patient-centered communication. CNLs are capable of teaching skills to enhance patient-centered care. They possess the knowledge to analyze gaps in care delivery systems that result from failures in establishing a nurse-patient communication (King & Gerard, 2013). These proficiencies reflect core CNL competencies including the ability to demonstrate effective communication, develop interpersonal relationships, and collaborate with the healthcare team – including the patient (American Association of Colleges of Nursing [AACN], 2013). Although CNLs were not designed for administrative roles, they function as bridges between point-of-care staff and administration (King & Gerard, 2013). They are skilled at unraveling the dynamics between patient satisfaction, health outcomes, and reimbursement. CNLs are also able to educate the nursing staff on how to use existing systems that facilitate communication, monitor its utilization, and lead practice changes when needed (Harris, Roussel, & Thomas, 2014).

John Kotter's Eight-Step Change Theory will be used as a framework for the proposed change in the microsystem. The change theory was initially developed to enable organizations to adapt to new realities necessitating change and improve their chances for success. The theory consists of eight stages that include: create a sense of urgency, creating the guiding coalition, developing a change vision, communicating the vision for buy-in, empowering broad-based action, generating short-term wins, planned to follow up with sustain acceleration, and institute change (The 8-Step Process For Leading Change, 2013). Considering that the unit underperformed in nursing communication, this Eight-Step change theory will be referenced to design a change in current communication methods between healthcare providers and patients (Patient Experience of Care Survey Results, 2016).

### **Methods**

In this microsystem, there are 28 beds that are served by nurses, physicians, nursing assistants, managers, and physical therapists, as well as other auxiliary staff members of the interprofessional team. This hospital serves over three million people from the surrounding communities as the only academic medical center and Level 1 trauma center with a Magnet Designation (UC Irvine Medical Center, 2016). This macrosystem provides medical care to a patient population composed of 45% White (not of Hispanic Origin), 34% Hispanic, 17% Asian/Pacific Islander, 2% African American, and 2% two or more ethnicities (Organizational Overview 1 Contextual Information, 2012). To address the healthcare needs of their patients, this hospital established a mission to "discover, teach, and heal" and a vision "to be among the best academic health centers in the nation in research, medical education, and excellence in patient care" by fulfilling a commitment "to bring personalized, leading-edge care to [patients] and [their] community" (UCI Mission, Vision and Values, n.d.).

Acutely ill adult patients with a variety of medical problems and diseases receive medical-surgical and telemetry services in this microsystem of focus (UC Irvine Medical Center, 2016). The microsystem disseminates specialty services to the patient population by supporting 44 full-time nurses and an interdisciplinary team that hosts other healthcare practices (UC Irvine Medical Center, 2017).

There is no formal process or policy in place regarding specific nursing communication practices, however, there is an expectation that nurses communicate with patients in a compassionate but professional manner. Current methods of communication include a change of shift report, nurse introductions, “Thank You” cards, post-discharge phone calls, and nurse manager rounds. Patterns regarding communication were analyzed through HCAHPS survey scores, which is how this institution measures quality and safety. Some of the questions on these HCAHPS surveys included “During this hospital stay, how often did nurses treat you with courtesy and respect?”, “During this hospital stay, how often did nurses listen carefully to you?” and “During this hospital stay, how often did nurses explain things in a way you could understand?” (Appendix F). In comparison to the national average, the hospital fell below at 80% with their HCAHPS survey scores (CMS, 2018; Patient Experience of Care Survey Results, 2016).

In conducting a Root Cause Analysis (RCA), an initial assessment was performed on the unit based on its dynamics, direct patient interactions, and communication with management and staffing. Additional research was conducted to determine the needs and deficiencies of the unit through HCAHPS survey scores prior to implementation of our initial intervention and will continue to utilize updated HCAHPS survey scores following our implementation to determine its effectiveness and overall patient satisfaction.

For additional clarification on the specific deficiencies in communication within the microsystem, a patient survey was created and given to every patient on the unit during a specific time frame. Every day for one week, our team performed leadership rounds and interviewed each patient (those that had not already been interviewed during a prior visit), as well as met and collaborated with the nursing manager for the unit as necessary. For the survey, there was no discrimination against specific participants; however, with the final intervention, the selected participants were awake, alert and oriented, English speaking patients without ailments that would prevent them from reading or writing.

If given the opportunity, the patient surveys would be re-distributed after a six-month period to determine whether or not the implementation process was going according to plan; however, outcomes and results will be measured through the following HCAHPS survey scores. Approval by the Institutional Review Board (IRB) was not acquired due to the fact that this project is a quality improvement study, and not a research study. However, the Standards of Conduct for this institution were reviewed and incorporated into the global aim statement of this project.

### **Results**

In August 2018, prior to assessment of the microsystem, the HCAHPS satisfactions scores were at the highest level they had been in over a year at 95.8% (CMS, 2018). During September 2018, as the microsystem was assessed, HCAHPS scores decreased to 79.6% (CMS, 2018). Prior to implementation of the intervention, satisfaction scores for October 2018, had decreased to 69% (CMS, 2018) (Appendix C). In order to assess the reasons behind variations in satisfaction with communication between nurses and patients in the microsystem, a root cause

and systems analysis was performed. The issues were broken down into processes, environment, resources, management, patient, and staff.

Within the processes portion of the analysis communication, issues existed because of an absence of bedside reporting, heavy nursing workloads which contributed to decreased time for face-to-face patient interactions, and resources available to decrease nurse workload such as the discharge lounge were not utilized. These processes were all seen as barriers resulting in a decrease of opportunity for patient communication. The microsystem environment consisted of small patient rooms, and several rooms with double occupancy, which did not allow for easy or comfortable conversations to take place between nurse and patient. Several interventions were often observed to be occurring at the same time, including physical therapy and nursing care. In already crowded rooms, with several interventions occurring at the same time, the patients were observed to be easily distracted. Environmental factors, such as these, were observed that may contribute to poor communication within the microsystem.

Although resources are available for nurses, they were not frequently utilized. Computers for charting are available in every patient's room, but because of the small spaces nurses often preferred charting at the nursing station, which resulted in frequent crowding. Many of the nurses demonstrated call light fatigue, and patients verbally stated their frustrations with not being able to speak directly to their nurse. Although electronic interpretive services with a wide variety of languages were available for communication, nurses were observed to frequently use family members or another staff member as an interpreter. When analyzing management issues regarding communication, several areas for improvement were recognized. Nurses were observed to voice their concerns about workload and relationships among the floor to the management. Nurses felt that expectations of the individual roles of staff on the floor were not

clearly defined, resulting in frustration because of the inconsistencies. Additionally, management attempted to round daily to each patient's room to discuss their experiences on the floor.

Unfortunately, due to busy management schedules, rounding was inconsistent, resulting in missed opportunities for communication with a nurse leader on the unit.

When analyzing the microsystem from the patient perspective, several areas for missed communication opportunities were identified. Hospital stays are stressful, with many different medications provided and interventions performed. This results in a great deal of information being provided to the patient throughout their hospital stay, which could easily become overwhelming. Additionally, this microsystem serves a wide variety of patients, with varying cultures, learning styles and healthcare literacy levels. Provision of verbal information was not always their best form of communication, especially if language barriers existed. Informative tools are available in a variety of languages but were not observed to be put to use. Lastly, during the assessment of the staff's relationship to poor communication, areas for improvement were identified. Staff were observed to frequently rush through patient interaction in order to move onto the next task. Many people voiced their concerns of feeling overworked and not supported. These feelings affected the culture on the floor, which was resistant to change. Overall, the root cause and systems analysis aided in identifying the driving issues that led to poor communication on this unit (Appendix A).

In order to gain a better understanding of the barriers affecting nurse-to-patient communication from the patient's perspective, questionnaires were conducted face-to-face with patients for a period of one week. The survey consisted of eight questions; six of those questions measured quantitative data requiring either a yes or no response. The last two items collected qualitative data by presenting open-ended questions allowing patients to freely share their

perception of the current communication processes in place. Furthermore, each question in the survey specifically focused on the topic of communication between the patients and their respective nurses.

Overall, three questions demonstrated statistical importance and generated an analysis requiring further attention and focus. One of those questions which asked, "Has the nurse explained your care for the day?" resulted in 37.5% of the patients responding "no." The second question which asked, "Was the report performed at the bedside?" presented with 36.6% of the patients responding "no." Lastly, the final question which asked, "Do you think it's important enough to be woken up in the mornings for the nurse to introduce themselves?" resulted in 70.7% of patients responding with "yes." Based on the results of these three questions, it is clear that the nurses on this unit are underperforming in these respective areas (Appendix B).

### **Implementation**

After obtaining results from the patient surveys, one-on-one meetings were scheduled with the unit nurse manager to discuss and identify how to gear implementation efforts toward improving communication between nurses and patients. It was also encouraged to participate during the unit practice council (UPC) meetings to help foster relationships with the nursing staff. This cultivated a collaborative environment that was conducive for delivering a presentation based on findings and generating support from key stakeholders. One of the key elements of the presentation that drew attention from the nursing staff during the UPC meeting was demonstrating that the hospital was underperforming when being compared to the national average. The presentation not only highlighted an alarming figure but also introduced the idea of implementing the Tell-Us Card and discussed how this tool can be utilized to improve patient outcomes, safety, satisfaction, communication, and HCAHPS scores.

Following the PowerPoint presentation, the Tell-Us Card was implemented within two weeks and with full support, the nurse manager assumed the responsibility to distribute the Tell-Us Cards and discuss their purpose and importance with nurses and patients. The unit nurse manager will distribute the Tell Us Cards during leadership rounds everyday between 9 A.M. through 11 A.M. and volunteers that typically are on the unit helping the nursing staff for three-hour shifts once a week will also be recruited to assist with the distribution of the cards. Between the presentation and implementation, the group reconvened to create and design the Tell-Us Card which has two sides and is to be used as a tent card. One side of the card states as follows: “We want to hear from you! What is important to you during your hospital stay?” The opposite side of the card provided a space for patients to respond to the following prompts: “This is important for me today ...”, and “This is important to me before discharge ...” (Appendix D).

Once the design of the card was approved by the nurse manager, prompts were created for the charge nurses to read to the staff (Appendix E). The prompts were created and designed with specific instructions for the day and night charge nurses to read to the staff during huddle at the start of their shift. The prompt for the day shift included instructions indicating that the nurse’s role is to pick up the card from the patient in the afternoon and address the patient’s concerns. If appropriate, these concerns may be incorporated into the plan of care for the day. The prompt for the night shift is a reminder to the staff that the day shift nurse should have collected the cards already, as well as addressed the concerns of the card. However, if there were any changes made since then, then the night shift would address those new concerns and incorporate them into the plan of care for the night. This not only serves as a reminder but also encourages nurse participation and maintenance of the Tell-Us Card.

The Tell-Us Card was used to enhance communication between nurses and patients because it is an affordable and straightforward tool that can be utilized in “clinical practice to improve patient participation in their own care” (Jangland, Carlsson, Lundgren, & Grunningberg, 2012). A similar intervention to the Tell-Us Card was implemented in the Triad for Optimal Patient Safety project in the U.S. and in a surgical care unit in Sweden. Findings from the study that took place on the surgical unit in Sweden indicated that the Tell-Us Card enabled patients to express what was most important to them during their hospitalization (Jangland, Carlsson, Lundgren, & Grunningberg, 2012). This encouraged patients to participate in their own care and were better informed of their health. The results from the Swedish study further supported that patients indeed more involved in their care because they felt comfortable using a tool that encouraged them to state questions or concerns that they would otherwise have not raised or addressed (Jangland, Carlsson, Lundgren, & Grunningberg, 2012). The Tell-Us Card is a simple intervention and its success and impact are based on whether nurses take a moment during their 12-hour shift to read the card, listen to the patient, and respond to their needs or concerns otherwise, implementation will be ineffective (Appendix G).

### **Cost Analysis**

It is expected that implementing the Tell-Us Card intervention will help increase the hospital’s opportunities for financial gains. As it was stated previously, the CMS provides an HCAHPS survey consisting of 32 questions in order to measure a patient’s experience of care, and this includes communication (Mehta, 2015). Currently, the CMS withholds about 1% of their Medicare reimbursements, and 30% of that percentage is related to the HCAHPS survey (Mehta, 2015). This suggests that there are likely substantial amounts of money that the hospitals may be potentially losing. Unfortunately, many of these financial numbers are kept confidential therefore

setting a limitation in determining how significant the loss is and what the potential cost-savings could be. However, while the Tell-Us Card was implemented to improve nurse-to-patient communication HCAHPS scores, it can also serve far greater clinical benefits like reducing medical errors.

According to Murphy and Dunn (2010), miscommunication is one of the most common causes of medical errors. Furthermore, one report conducted by Shreve et al. (2010), found that medical errors account for about 1.5 million of the 6.3 million injuries in the United States. The report also revealed that the cost per medical error averages about \$13,000 and costs the United States about \$19.5 billion (Shreve et al., 2010). Based on this data, it is clear that medical errors can have a significant financial impact on the overall healthcare system and creates an opportunity for change and potential savings. This is where the Tell-Us Card can have a considerable influence; by increasing communication between nurses and patients, medical errors can potentially decrease.

Overall, the project is expected to cost approximately \$571 for the startup year and subsequent years to follow. This cost is based solely on the recurring charges which include the reams of printer paper and ink cartridges. However, areas of cost savings are expected to be achieved through existing and reusable materials currently in place; this includes the computer system, scissors, printer, and workstation. Therefore, if the yearly costs average \$571 and the average costs per medical error is \$13,000, this creates an opportunity to save \$12,429 per year. This means that the unit will save \$21.77 for every \$1 invested in implementing the Tell-Us Card program.

### **Evaluation**

The efficacy of the Tell-Us Card intervention will be evaluated by patient satisfaction scores through HCAHPS surveys (Appendix F). These surveys aid in identifying if patients' perceptions of nursing communication and if they have improved through the intervention. The HCAHPS survey is a reliable method to assess the success of this intervention because it is a systematic survey that evaluates patient experiences in a hospital setting (Weidmer, Brach, Slaughter, & Hays, 2012). This evaluation process will take place six months post-implementation of the Tell-Us Card intervention. HCAHPS surveys are conducted by taking a random sample of adult inpatients between 48 hours and six weeks after discharge (CMS, 2017). These surveys are conducted via mail, telephone calls, mail with telephone follow-up, or active interactive voice recognition (CMS, 2017). Due to the method of the HCAHPS surveys, the time frame of six months was chosen to obtain the most accurate results within this microsystem.

If more time would have been allotted for this intervention, ideally patient survey questionnaires would have been re-conducted within this microsystem. This patient survey would have been the same survey from the pre-implementation process of the Tell-Us Card intervention. The survey would have remained unchanged in order to standardize the response data. This survey would have been valuable in determining whether the Tell-Us Card had an immediate effect within the microsystem.

The Plan Do Study Act (PDSA) cycle approach will be taken as part of the future evaluation process of the Tell-Us Card intervention (Coury et al., 2017). After evaluation of the HCAHPS scores in six months, the microsystem will be reassessed. The reassessment will include a post implementation survey for the nurses in order to identify how improvements can be made to the intervention. This will also help identify whether nurses and their patients are actively participating in this intervention.

### **Discussion**

Before implementation of the Tell-Us Card within this microsystem, there was no established technique that allowed patients to be able to freely communicate their needs. After further assessments were made, it was determined that there was a need to identify what is important to these patients during hospitalization. Sometimes what patients identify as important to them during their hospital stay may not correlate with what the nurses perceive to be important for their patients. This is most likely why the HCAHPS for this unit are not where they should be. Whether the patient need has to do with the overall quietness of their stay or the need to know more about the side effects of their medications, all patient needs are vital in understanding how to affect patient satisfaction scores. If this patient need is identified, discussed openly with the patient, and then acknowledged by the nurse, patient communication, as well as patient satisfaction scores, could improve.

Limitations within this intervention included language barriers, patient/staff compliance, and timing. The first limitation was that the Tell-Us Cards were only provided in English. There should have been multilingual versions of this intervention because a somewhat significant number of patients within this microsystem did not have English as their primary language. The second limitation was that there may be problems with patient and staff compliance with this intervention. The likelihood is unknown on whether the patients within this particular unit will take the time to fill out the Tell-Us Card or not. It is also unknown if these nurses will collect the Tell-Us Card and incorporate the patient needs into their care plans on a daily basis. The third limitation was the timing involving the initial microsystem assessments (Appendix B). When the initial patient survey was taken in order to assess communication on the unit, patients sometimes

were asleep, had left to go to radiology or were in the middle of a physical assessment. This affected the overall number of patients that were able to be surveyed on the unit.

From a system level perspective, the aspects of this work that were complex and required longer time to attend to included staff culture and processes, staff buy-in, and time. Working with the nursing staff and their schedules regarding the implementation process was rather difficult. If there would have been no time limit, more diplomacy, and an understanding of the unit workflow may have aided in implementing this intervention. Also, it would have been ideal to educate the staff during each change of shift while implementing the Tell-Us Card for the first two weeks.

Staff buy-in within this unit would have been easier to obtain if more time was allotted. During the UPC meetings with staff, support was shown on behalf of most staff members and nurses. However, if each and every nurse does not support the intervention, compliance may be affected which could affect the overall patient satisfaction scores on this unit. Time restrictions limited the research data for this intervention as well as the initial patient assessments discussed previously.

In terms of nursing relevance, the overall goal is to improve the deliverance of holistic, competent, and compassionate care based on evidence-based practices that encompasses ethical components of justice, beneficence, non-maleficence, accountability, fidelity, autonomy, and veracity. Improving nurse-to-patient communication through the Tell-Us Card will facilitate trusting relationships within the interprofessional team, thereby helping to improve patient satisfaction and outcomes. Patients need to feel comforted during their hospital stay since it sometimes can be an extremely difficult moment in time. Through the Tell-Us Card, these concerns and opinions can be heard. If the patients participate in this part of their care, this can

improve nurse to patient communication as well as patient satisfaction scores for this unit.

The CNL is important in conducting a quality improvement project such as this for a few reasons. The CNL specializes in communication, interdisciplinary collaboration, and is at the center of many different communication systems (King & Gerard, 2013). This role is able to coordinate with patients, family, staff members at all levels (e.g. nurses, nurse managers, certified nursing assistants, physicians) in order to produce quality patient outcomes within a hospital setting (King & Gerard, 2013). It is also important to acknowledge that poor communication can also lead to patient harm and unsafe care (King and Gerard, 2013). This is another reason why it is important that CNLs conduct this project. Again, since CNLs specialize in communication, it is most beneficial for patient and staff involved follow a structured plan in improving patient to nurse communication within this unit.

As CNLs, an RCA was conducted initially during the first assessment of the microsystem. With evidence-based practice and use of the Tell-Us Card by the CNL, improvements in healthcare outcomes can be made on this unit. It is also understood that CNLs are lateral integrators which means that they essentially act as air traffic control guides in healthcare (King & Gerard, 2013). Lateral integrators are able to involve all staff members, the patient and family in patient care. CNLs are essential in the guidance of a quality improvement project such as the Tell-Us Card because they are constantly working toward the goal of quality patient care.

### **Future Directions**

Potential changes for the process in the future include more direct communication with the nurses on the floor. Because both the nurse and the patient are the sole parties of focus, the aim is to facilitate meaningful relationships between the two parties to cultivate a better

understanding of perspectives and concerns regarding communication and the intervention -- particularly the nurse. All members of the interprofessional team, however, are integral members of overall communication and patient satisfaction. This would require not only the nurses to become more actively involved in this project, but hopefully transfer to all individuals involved in patient care.

The sustainability plan involves the PDSA cycle for evaluation, a post implementation survey, a review of the HCAHPS scores, and determination of the effectiveness of the Tell-Us Card overall. In order to determine the effectiveness, the manager on the unit will be surveyed. The nurse and patients within the unit will also be assessed in order to determine if both parties are complying to the intervention. In the post implementation survey, all patients will be re-interviewed in order to determine if their needs are being met. This survey will also ideally determine if the Tell-Us Cards are effectively opening up communication between the patient and nurses. It is important to ask the patients in this post implementation survey if they are feeling heard by the nurses and if the nurses on the unit are using the Tell-Us Cards.

### **Conclusion**

In summary, survey tools revealed that room for improvement in nursing communication was evident within this microsystem. After thorough assessments were made, it was determined that the Tell-Us Card was the most effective and appropriate communication method to use in order to create positive change. This intervention will ideally improve communication as well as patient satisfaction scores on the unit by opening up communication between nurses and their patients. In six-month's time, HCAHPS scores are predicted to increase and be sustained overtime within this microsystem.

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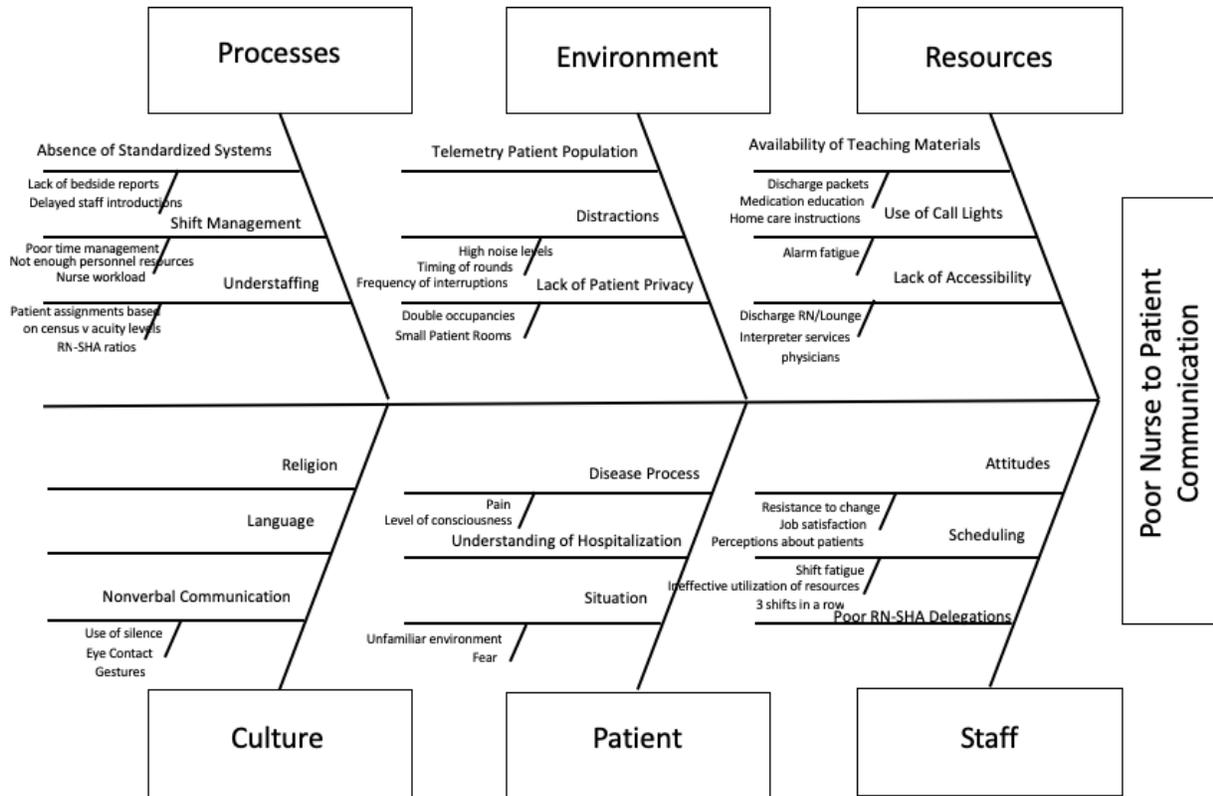
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Appendix A

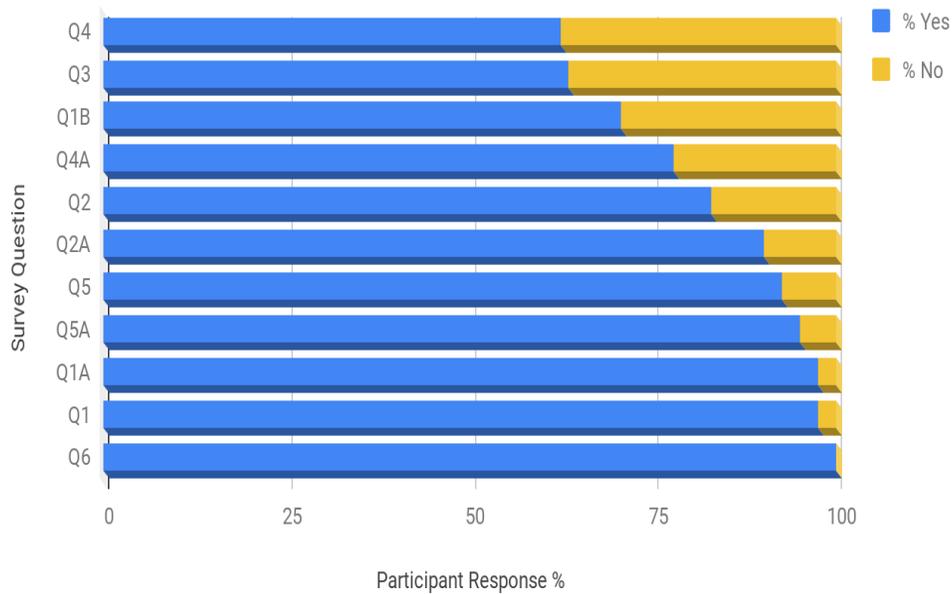
Root Cause Analysis



Appendix B

Telemetry Medical/Surgical Unit Patient Survey Results

Nursing Communication - Patient Survey Results



Quantitative Data

Q1	Did the nurse introduce him or herself?	97.6% yes 2.4% no
Q1A	Do you think it was important for the nurse to introduce him or herself?	97.6% yes; 2.4% no
Q1B	Do you think it's important enough to be woken up in the mornings?	70.7% yes; 29.3% no
Q2	Did the nurse address you by name?	82.9% yes; 17.1% no
Q2A	Was this important to you?	90.2% yes; 9.8% no
Q3	Was the report performed at the bedside?	63.4% yes; 36.6% no
Q4	Has the nurse explained your care for the day?	62.5% yes; 37.5% no
Q4A	If yes, was it explained to you in a manner that you understood the care?	77.8% yes; 22.2% no
Q5	Were you given an opportunity to communicate your concerns with a nurse?	92.7% yes; 7.3% no
Q5A	Did you feel like the nurse was listening to you?	95.1% yes; 4.9% no
Q6	Did the nurse answer your questions?	100% yes; 0% no

Qualitative Data

Q7 How and when do you communicate with your nurse?

Waits for RN to enter room.

Call light if it's important.

Q8 How can nurses improve their communication with you?

Most patients had nothing to add.

Other responses:

Be less rushed.

Provide updates with vitals check.

Explain medications.

Address with Mr. or Mrs.

Update whiteboard.

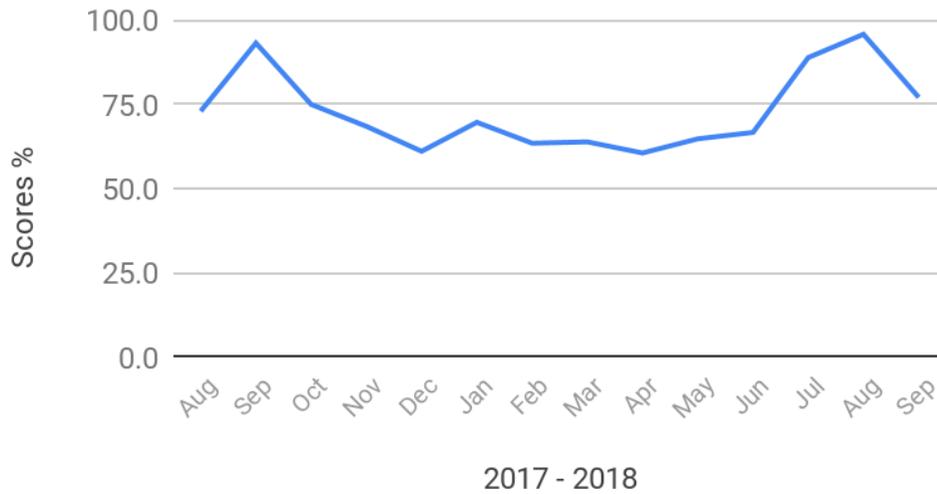
Introduce self entering rooms.

Smile.

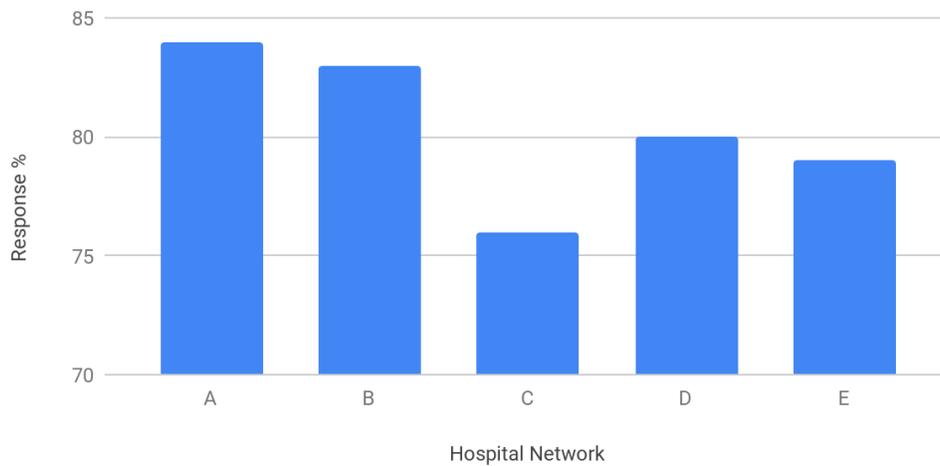
Appendix C

HCAHPS Survey Responses

Microsystem's HCAHPS Nursing Communication Scores



Patients who reported that their nurses "Always" communicated well 10/1/16-9/30/17



C: microsystem data

(CMS, 2018)

Appendix D  
Tell-Us Card



What is important to you during your hospital stay?

***WE WANT TO HEAR FROM YOU!***

---

**This is important to me today:**

---

---

---

**This is important to me before discharge:**

---

---

---

## Appendix E

## Charge Nurse Prompts



## DAY SHIFT

**TELL-US CARD**

The USF students will be implementing a communication tool called the Tell-Us card, which multiple studies have shown significant improvement in overall communication.

The aim of this project is to improve communication issues on the floor and improve HCAHPS.

**DIRECTIONS:**

- 1. The cards and pens will be passed out during rounds.**
- 2. The cards will be completed by the patients.**
- 3. Nurses will pick up the cards after 12 noon.**
- 4. Patients and nurses will have a discussion about the response.**
- 5. Nurses will tailor care according to patient responses.**

The data we collect will be published, so please remember to have a discussion about the cards with your patients.

**THANK YOU!**

## NIGHT SHIFT

**TELL-US CARD**

The USF students will implement a communication tool called the Tell-Us card, which multiple studies have shown significant improvement in overall communication.

The aim of this project is to improve communication issues on the floor and improve HCAHPS.

**DIRECTIONS:**

- 1. The cards will be passed out, completed, and picked up during the day shift.**
- 2. Patients and the day shift nurses will have a discussion about the response.**
- 3. The nurses will tailor the patient's care according to what was written on the card.**
- 4. Your role will be to follow up on the patient responses and continuing to tailor their care.**

The data we collect will be published, so please remember to have a discussion about the cards with your patients.

**THANK YOU!**

Appendix F

HCAHPS Survey Questions

**HCAHPS Survey**

**SURVEY INSTRUCTIONS**

- ◆ You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient.
- ◆ Answer all the questions by checking the box to the left of your answer.
- ◆ You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:
  - Yes
  - No → *If No, Go to Question 1*

*You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.*  
 Please note: Questions 1-25 in this survey are part of a national initiative to measure the quality of care in hospitals. OMB #0938-0981

Please answer the questions in this survey about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

**YOUR CARE FROM NURSES**

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
  - <sup>1</sup>  Never
  - <sup>2</sup>  Sometimes
  - <sup>3</sup>  Usually
  - <sup>4</sup>  Always
2. During this hospital stay, how often did nurses listen carefully to you?
  - <sup>1</sup>  Never
  - <sup>2</sup>  Sometimes
  - <sup>3</sup>  Usually
  - <sup>4</sup>  Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?
  - <sup>1</sup>  Never
  - <sup>2</sup>  Sometimes
  - <sup>3</sup>  Usually
  - <sup>4</sup>  Always
4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
  - <sup>1</sup>  Never
  - <sup>2</sup>  Sometimes
  - <sup>3</sup>  Usually
  - <sup>4</sup>  Always
  - <sup>9</sup>  I never pressed the call button

**YOUR CARE FROM DOCTORS**

5. During this hospital stay, how often did doctors treat you with courtesy and respect?
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always
6. During this hospital stay, how often did doctors listen carefully to you?
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always
7. During this hospital stay, how often did doctors explain things in a way you could understand?
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always

**THE HOSPITAL ENVIRONMENT**

8. During this hospital stay, how often were your room and bathroom kept clean?
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always
9. During this hospital stay, how often was the area around your room quiet at night?
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always

**YOUR EXPERIENCES IN THIS HOSPITAL**

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
- <sup>1</sup>  Yes  
<sup>2</sup>  No → If No, Go to Question 12
11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always
12. During this hospital stay, did you have any pain?
- <sup>1</sup>  Yes  
<sup>2</sup>  No → If No, Go to Question 15
13. During this hospital stay, how often did hospital staff talk with you about how much pain you had?
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always
14. During this hospital stay, how often did hospital staff talk with you about how to treat your pain?
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always

15. During this hospital stay, were you given any medicine that you had not taken before?

- <sup>1</sup>  Yes
- <sup>2</sup>  No → If No, Go to Question 18

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?

- <sup>1</sup>  Never
- <sup>2</sup>  Sometimes
- <sup>3</sup>  Usually
- <sup>4</sup>  Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

- <sup>1</sup>  Never
- <sup>2</sup>  Sometimes
- <sup>3</sup>  Usually
- <sup>4</sup>  Always

**WHEN YOU LEFT THE HOSPITAL**

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?

- <sup>1</sup>  Own home
- <sup>2</sup>  Someone else's home
- <sup>3</sup>  Another health facility → If Another, Go to Question 21

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

- <sup>1</sup>  Yes
- <sup>2</sup>  No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

- <sup>1</sup>  Yes
- <sup>2</sup>  No

**OVERALL RATING OF HOSPITAL**

Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?

- <sup>0</sup>  0 Worst hospital possible
- <sup>1</sup>  1
- <sup>2</sup>  2
- <sup>3</sup>  3
- <sup>4</sup>  4
- <sup>5</sup>  5
- <sup>6</sup>  6
- <sup>7</sup>  7
- <sup>8</sup>  8
- <sup>9</sup>  9
- <sup>10</sup>  10 Best hospital possible

**22. Would you recommend this hospital to your friends and family?**

- Definitely no
- Probably no
- Probably yes
- Definitely yes

**UNDERSTANDING YOUR CARE WHEN YOU LEFT THE HOSPITAL**

**23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.**

- Strongly disagree
- Disagree
- Agree
- Strongly agree

**24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.**

- Strongly disagree
- Disagree
- Agree
- Strongly agree

**25. When I left the hospital, I clearly understood the purpose for taking each of my medications.**

- Strongly disagree
- Disagree
- Agree
- Strongly agree
- I was not given any medication when I left the hospital

**ABOUT YOU**

There are only a few remaining items left.

**26. During this hospital stay, were you admitted to this hospital through the Emergency Room?**

- Yes
- No

**27. In general, how would you rate your overall health?**

- Excellent
- Very good
- Good
- Fair
- Poor

**28. In general, how would you rate your overall mental or emotional health?**

- Excellent
- Very good
- Good
- Fair
- Poor

**29. What is the highest grade or level of school that you have completed?**

- 8th grade or less
- Some high school, but did not graduate
- High school graduate or GED
- Some college or 2-year degree
- 4-year college graduate
- More than 4-year college degree

- 30. Are you of Spanish, Hispanic or Latino origin or descent?**
- <sup>1</sup>  No, not Spanish/Hispanic/Latino
  - <sup>2</sup>  Yes, Puerto Rican
  - <sup>3</sup>  Yes, Mexican, Mexican American, Chicano
  - <sup>4</sup>  Yes, Cuban
  - <sup>5</sup>  Yes, other Spanish/Hispanic/Latino
- 31. What is your race? Please choose one or more.**
- <sup>1</sup>  White
  - <sup>2</sup>  Black or African American
  - <sup>3</sup>  Asian
  - <sup>4</sup>  Native Hawaiian or other Pacific Islander
  - <sup>5</sup>  American Indian or Alaska Native

- 32. What language do you mainly speak at home?**
- <sup>1</sup>  English
  - <sup>2</sup>  Spanish
  - <sup>3</sup>  Chinese
  - <sup>4</sup>  Russian
  - <sup>5</sup>  Vietnamese
  - <sup>6</sup>  Portuguese
  - <sup>9</sup>  Some other language (please print):  
\_\_\_\_\_

**THANK YOU**

**Please return the completed survey in the postage-paid envelope.**

**[NAME OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]**

**[RETURN ADDRESS OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]**

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## Appendix G

## Tell-Us Card Protocol

1. Manager, Assistant Manager, or volunteer will distribute cards during morning rounds between 9 A.M. - 11 A.M.
2. Patients will complete the card.
3. Collect completed cards from patients in the afternoon.
4. Facilitate an open dialogue with patients about what was expressed in the card.
5. Incorporate needs into plan of care.
6. Evaluate and continue addressing completion of needs with patient until next morning round.