Doctoral Nursing Practice Quality Improvement Project Manuscript:

Commit to Sit

by

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Abstract

Problem & Purpose: The patient's perspective on what embodies high-quality care is becoming an increasingly critical aspect to quality improvement opportunities and one that has traditionally not been prioritized in health care. Presently, HCAHPS scores on an inpatient specialty surgery medical-surgical unit in Baltimore, MD, ranked 12% in response to whether nursing staff is careful listening to their patients, the benchmark is 55%. This quality improvement initiative will implement nurse-motivated formal patient-centered conversation in an inpatient hospital setting. The initiative was implemented over a 15-week period in the fall of 2022. This quality initiative is expected to improve patient satisfaction and patient perceptions of careful listening from nursing staff. The evidence-based intervention recommendation includes each nurse sitting with three of their six patients a shift to engage in a patient centered conversation for three minutes each.

Methods: Data were collected using a patient survey and intervention completion audit forms. Frequency distributions, run-charts, and t-tests were used to demonstrate intervention outcomes. To protect confidentiality during data collection the patients' surveys were collected anonymously.

Results: On average the day shift nurses completed the intervention 8.33% of the time and night shift nurses 1.87% of the time. Despite the low intervention adherence, 91.64% of patients felt carefully listened to. Conversely, only 81.11% of nurses were reported sitting at the patients' bedside when carefully listening. Patients' perception of careful listening and staff sitting at the bedside were found to not be statistically significant, $p=0.11$.

Conclusions: Increasing patient loads, nurse workflow demands, timing constraints, COVID-19 pandemic aftershock, and perceived importance of implementation among staff within this inpatient unit were limitations recognized by staff to implement intentional careful listening with their patients. However, patients' satisfaction continued to improve without correlation to nurses sitting at the bedside. Therefore, carefully listening strategies should emphasize quality of conversation and timeliness of conversation rather than sitting at the bedside to improve patient satisfaction. Knowledge of supporting conversational strategies, verbal and nonverbal, may provide further information on the patients' perspective of careful listening.

Keywords: carefully listening, inpatient, nursing, quality improvement

Problem Description

Patient centered care is an evolving concept that has traditionally not been prioritized in health care (Santana et al., 2018). Disregarding the patient as a holistic and contributing facet to their health care has been seen to leave patients feeling frustrated and dissatisfied. The patient's perspective on what embodies high-quality care is becoming an increasingly critical aspect to quality assessment and improvement opportunities (Adamson et al., 2012). Understanding how patients perceive effective communication is essential to improving patient outcomes and increasing patient satisfaction (Trotta et al., 2020). In the inpatient hospital setting, nurses have a large influence on patient experiences and the ability to foster a patient-centered environment.

Across the country, hospital patient satisfaction is measured by a standardized 29 question Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (AHRQ, 2021). Randomized patients receive this survey 48 hours to 6 weeks after hospital discharge to examine 10 comprehensive composite measures (AHRQ, 2021). Within each domain are several questions that elicit more specific information. For instance, in the nurse communication domain, there are specific questions that target courtesy and respect, clear communication, and careful listening. Between the months of January and March of 2021, a specialty surgery acute care inpatient unit in Maryland scored 12% to the question "how often did nurses listen carefully?" question. Prior to January of 2021, this unit scored 75% and above. The hospital benchmark for this question is 55%. During the same time frame, other hospitals in the geographic area scored 69% to the careful listening question, whereas the state of Maryland averaged 75% satisfaction in the nurse communication measure (AHRQ, 2021). The most probable root cause for this sudden drop in the top box score may be related to increased nurse workload through the COVID-19 pandemic and subsequent workflow changes.

Specific Aims and Available Knowledge

An integrative evidence review and synthesis (Table 1 and 2) was performed to identify possible interventions that could improve patients' satisfaction regarding effective communication strategies. This seven-article review included two randomized control trials, two quasi-experimental studies, and three qualitative studies. Two studies (Swayden et al., 2012 & Merel et al, 2016) report improved responses regarding physician listening when providers sit during their patient interview, with Merel et al. (2016) reporting an increase in the 'always' response to the careful listening domain on the HCAPHS survey. More specifically, Orloski et al. (2019) reports that providers sitting at any point of the encounter resulted in improved responses of politeness, caring, listening, informed, and timely ($p<0.0001$). A level II, grade B, quasi experimental study found that implementing the Commit to Sit initiative improved nurse communication composite scores from the 9th percentile to the 43rd percentile within one year (Lidgett, 2016). Three studies (Trotta et al., 2020; Loos, 2001; & Adamson, 2012) report that nurse behaviors related to increased nursing communication scores and improved patient satisfaction are creating a welcoming environment, using active listening with eye contact, and employing a therapeutic use of presence while seated at the bedside. Additionally, Lidgett (2016) reports that the Commit to Sit initiative improved nurse communication composite scores from the 9th percentile to the 43rd percentile within one year.

The evidence supports that nurses sitting with patients and initiating patient-centered conversation is likely to improve patient satisfaction and patient perceptions of caring and listening. Therefore, the purpose of this DNP project is to implement and evaluate the effectiveness of nurse-motivated formal patient-centered conversation in an inpatient hospital setting from August 29, 2022 to December 5, 2022. The primary process goal is that 100% of

unit nurses will sit and complete the intervention with 50% of their patient team. The short-term primary outcome goal is that 100% of patients perceive that they were carefully listened to after the intervention. The long-term outcome goal is to see HCAHPS top box scores on careful listening increase from 12% to at least the national benchmark of 55%.

Rationale/Framework

The theoretical framework chosen for this quality improvement project is the Knowledge to Action framework (Figure 1). This cyclical framework emphasizes the importance of knowledge generation and knowledge application. Knowledge generation is accomplished by completing an evidence review and synthesis. Then, the knowledge application cycle utilizes the knowledge obtained from the evidence review and tailors it to the specifics of the implementation environment and capabilities. The adjusted knowledge is then put into action and evaluated for barriers and facilitators that will motivate continued process changes and monitor knowledge use. Utilizing this framework, the proposed intervention is expected to be successful because the framework outlines a synergic process that includes an extensive knowledge inquiry, comprehensive assessment of current practice, acknowledgement of potential barriers and/or facilitators, and thorough outcome monitoring.

Using the KTA framework, the identified problem for this project is the recent decrease in HCAHPS scores in the careful listening domain. An integrative evidence review was completed and synthesized to discover a feasible solution. The Commit to Sit initiative has been linked to improving patient satisfaction scores and thereby promoting patient's recovery from the hospital. This intervention will be implemented while assessing knowledge use and potential barriers to intervention success. Outcomes will be evaluated and inspire intervention adjustments that will further improve patient satisfaction scores while remedying workflow delays.

Methods

The proposed evidence-based intervention was implemented on a specialty medical-surgical inpatient unit. This 32 bed unit houses patients that are under a multitude of services: neuro-spine, gynecology, urology, general surgery, plastics reconstruction, antepartum, postpartum, bariatrics, and general medicine. The nurse-to-patient ratio has consistently been 1:6 since the start of the COVID pandemic, even for charge nurses. Since this unit mainly serves as a post-surgical floor, each nurse typically has two discharges and subsequently two admissions from the post-anesthesia recovery unit, emergency department, or primary care office each shift. Currently, there is a harmonious, diverse group of 24 nurses that range from working on the unit for less than a year to 30 years. Prior to implementation, each nurse and newly hired nurse was given a contract that certified their agreement to participate in this quality improvement project.

The evidence-based recommendation included the institution providing a chair, unit nurses sitting at the patient's eye level, giving the patient their undivided attention, and asking conversational questions in a slow manner. These patient-centered conversations were rooted in learning more about the patient beyond their medical care by using active listening tactics such as making eye contact, sitting in an inviting posture, nodding when appropriate, avoiding interruptions, and asking follow-up questions. By the end of the shift, each nurse reported which patients received the intervention. To initiate the intervention, the project lead placed communication strategy cheat sheets (Figure 2) on each patient room computer, ensured there is a chair in each patient room, and affirmed that each participating nurse has signed their agreement to perform the intervention. It was also expected that each nurse will give the participating patient a post-intervention survey to detail their perception of the intervention.

The implementation plan included multiple strategies that are individualized to this unit to improve intervention uptake. To maintain accountability among the unit, staff signed formal commitments via individual contracts and received weekly reports on patient feedback from their post-intervention surveys. The prior HCAHPS data were used to produce buy-in for implementation assimilation. Monthly shared governance meetings functioned as the collaboration and communication tactic to assess intervention uptake. Patient surveys and nurse documentation auditing were completed to monitor data and identify barriers/facilitators. Continuing education was completed by reviewing data at monthly meetings and through weekly emails. The sustainability plan includes engaging all charge nurses as project champions, continuously reviewing barriers and facilitators through monthly meetings, and following HCAHPS trends. The implementation team includes the Unit Manager, Unit Education, Professional Nurse for the hospital, Staff Nurses, Charge Nurses, and the Unit Director.

To determine the process change, functional measures were observed because they would demonstrate the intervention's feasibility on a very busy inpatient medical-surgical unit. The operational definition of the process goal is that 100% of nurses will sit with 50% of their patient team for three minutes or more. The outcome change was determined using clinical measures because the goal of this initiative was to improve patient-centered care delivery. The operational definition of the outcome goal is that 100% of patients report feeling carefully listened to after the intervention. The survey used to assess the patients' perspective was not tested for reliability or validity.

To assess the impact of the intervention, patient surveys were distributed electronically, via a QR code, or in physical paper form to each patient after the nurse spoke with them. These surveys were completed and submitted anonymously but nursing staff was asked to glance over the

survey to ensure completeness prior to submission. The intentional effort to distribute these surveys directly after the patient centered conversation ensured that the recorded outcomes were attributed to the intervention that took place.

Initially, the quantitative data submitted from the audit forms were observed using descriptive statistics. These statistics were averaged separately for day shift and night shift and then grouped weekly to demonstrate nursing staff completion. The inferences made from this data was pivotal in understanding barriers associated with night shift timing and/or weekend versus weekday workflow changes. These methods aligned with the process goal to determine the intervention uptake and subsequent feasibility for long-term sustainability.

Separately, the patient surveys were completed via Likert scale and yes or no questions. This allowed for the patient surveys to also be analyzed quantitatively. The inferences made from this data allowed for comparisons to be made on what effected a patients' perception of carefully listening and how they perceived nurses sitting at the bedside with them. These methods aligned with the outcome goal to determine if the patients are perceiving careful listening based on physical attributes, such as sitting, or based on spending quality conversational time at the beside.

Ethical aspects and conflicts of interest for this intervention were addressed by a formal ethics review with the clinical site representative and clinical site sponsor. University of Maryland's IRB process and the facility's IRB process have approved this initiative. The HCAHPS outcome measure is endorsed by the National Quality Forum.

Records will be electronically tracked onto REDCap, a HIPAA compliant password protected platform to continue to protect confidentiality. There was an initial resistance from nursing staff to assist the patient in completing the survey using the QR code that auto populated

into the REDCap. To protect the confidentiality of those involved, paper logs and paper notes were be stored in a locked cabinet within a locked room only accessible to hospital staff. Post intervention surveys and audit forms were collected anonymously.

Results

The process goal was utilized to monitor intervention completion (Figure 7). Week 1 does not have data because it was focused on pre-implementation preparation and education. Initially, the first five weeks of implementation revealed a 15.72% intervention completion average for day shift and a 3.45% intervention completion average for night shift. At this time, the unit had a shared governance meeting that provided an opportunity for continued encouragement and uptake assessment. Night shift reported significant barriers with the timing of the intervention and finding unused patients that did not receive the intervention during day shift. Staff were encouraged to communicate shift to shift which patient the intervention was performed on. The second five weeks showed a steady decline in adherence to intervention completion; 4.78% for day shift and 0.71% for night shift. These weeks had significant barriers that prevented project sustainability. Simultaneously, the head charge nurse was out for 10 days due to COVID-19 illness and the main project champion was on a mission in Guatemala for three weeks. Through weeks 5 and 7, the patients present on the unit had become increasingly more ill and required substantially more intense nursing care. This left staff feeling underwhelmed and exasperated to the point that the Commit to Sit initiative lost prioritization. It was found that majority of nurses were completing the intervention but were not receiving credit via the audit forms or patient surveys. Also, during these weeks, the monthly shared governance was canceled because monthly competencies needed to take place. To combat these barriers, a poster presentation was given during the annual competency check that encouraged staff to

observe data trends and invoke motivation to implement the intervention. Also, the audit forms title was adjusted from ‘charge nurse audit forms’ to ‘audit forms’, in hopes of improving auditing documentation by including non-charge nurse staff to initiate the forms each shift. Lastly, greater emphasis was placed on staff distributing the surveys to get full credit for the intervention that they do on the daily basis already. The remainder of project implementation showed little changes among adherence; 4.49% completion for day shift and 1.43% for night shift. These slight changes were noted partially because day shift nurses were tasked with rotating to night shift for census balancing. Overall, the intervention was implemented 8.33% of the time on day shift and 1.87% of the time on night shift which did not meet the 50% goal.

The outcome goal was used to monitor patient perception of the intervention (Figure 8). Overall, there has been a consistent appreciation from patients that have received the intervention. Over the last ten weeks of implementation, 91.64% of patients have reported feeling carefully listened to after receiving the intervention. However, only 81.11% patients report that their nurse sat at the bedside with them during the intervention. Specifically, it is seen on weeks 3 where nearly 100% of patients reported feeling carefully listened to but only 50% of staff sat with these patients. Another example is week 5 that showed 98% of patients feeling carefully listened to but only 60% of staff sat with these patients. These data points are not consistent with the initial evidence review. To establish a relationship, a dependent t-test was completed that revealed that patients reporting that they feel carefully listened and staff sitting at the bedside were not statistically significant ($p=0.11$). When compared to the initial HCAHPS survey scores, the careful listening category improved to 92% during the weeks of implementation. Evidence was gathered for this project a year and a half before the project was implemented, but the preceding month before implementation exhibited a careful listening score

of 15% for the above-mentioned unit. Therefore, there was still a considerable gap in the unit's ability to carefully listen and the HCAHPS survey results show an outstanding improvement.

Discussion

Increasing patient loads, nurse workflow demands, timing constraints, COVID-19 pandemic aftershock, and perceived importance of implementation among staff within this medical-surgical unit were limitations for staff to implement intentional careful listening with their patients. However, patients' satisfaction continued to improve without correlation to nurses sitting at the bedside. Therefore, the key finding from this quality improvement project is that carefully listening strategies should emphasize quality of conversation and timeliness of conversation rather than sitting at the bedside to improve patient satisfaction. It is possible that performing this intervention on a population that received nursing care for 12 hours from one direct nurse, the act of sitting at the bedside may not be as important to the patients as previously found in evidence. It should also be acknowledged that majority of the data retrieved was based on self-reporting via survey or auditing forms that may require additional observation for validity. Knowledge of supporting conversational strategies, verbal and nonverbal, may provide further information on the patients' perspective of careful listening.

Implementation of this initiative required no additional cost to the unit or the facility. The benefit of this project can only be viewed on a small scale due to the low staff adherence of implementation, however the benefit seen in patient perception of feeling carefully listened to is vast and profitable for all parties involved. Further cost/benefit analysis could be completed to compare patient adherence and/or understanding of their plan of care when the patient reports feeling carefully listened to.

Conclusion

Despite the low implementation rate for this QI project, patient centered conversations with special attention to nonverbal, active listening skills is seen to improve patients' perception of careful listening. The implications for practice are based on this satisfied patient perception and include ensuring staff have adequate time to include patient centered conversation with each of their patients. The idea and/or data alone are great in promoting this change, but staff must also have the opportunity within their workflow to implement an intervention that is intended to appear unrushed and genuine. The root cause analysis was found to be true in that fundamental changes system-wide will need to be in place to actively place more effort in providing care that is patient centered and authentic.

The strengths associated with this project include many potential patients that were able to receive the intervention, rotating staff schedules to reduce individual workflow burden, minimal cost to the facility, and ease of documentation tools. Each of these strengths will aid in continued sustainability through the awareness and commitment of the unit staff. Future QI initiatives could include attention on increasing feasibility for staff to implement, using validated survey tools, and defining careful listening attributes that warrant intervention success.

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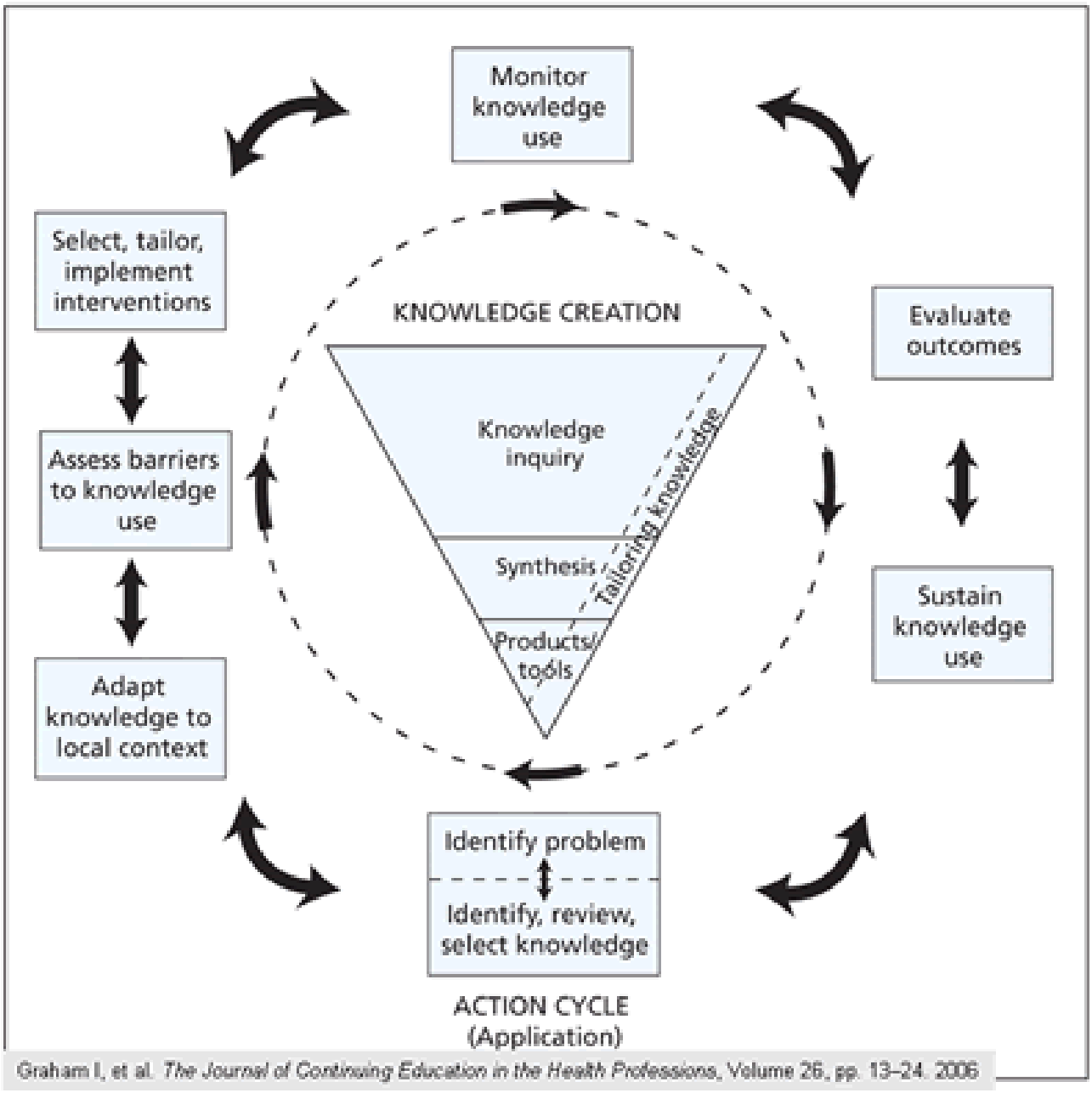
World Health Organization. (2022). Knowledge to action framework. https://www.who.int/reproductivehealth/topics/best_practices/greatproject_KTAframework

Figures

Figure 1

Knowledge to Action Framework



Note: World Health Organization (2022).

Figure 2

Fishbone Diagram

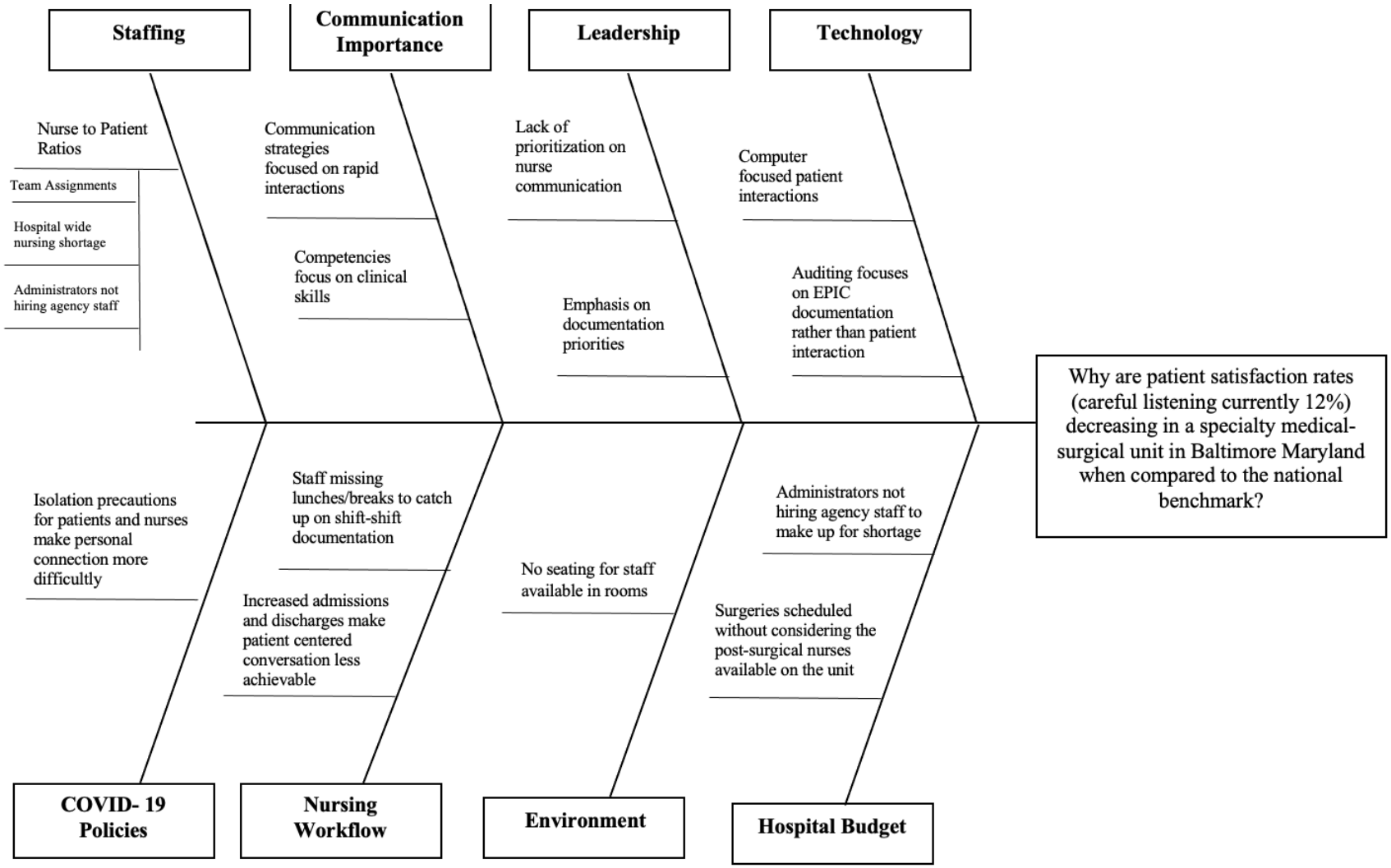
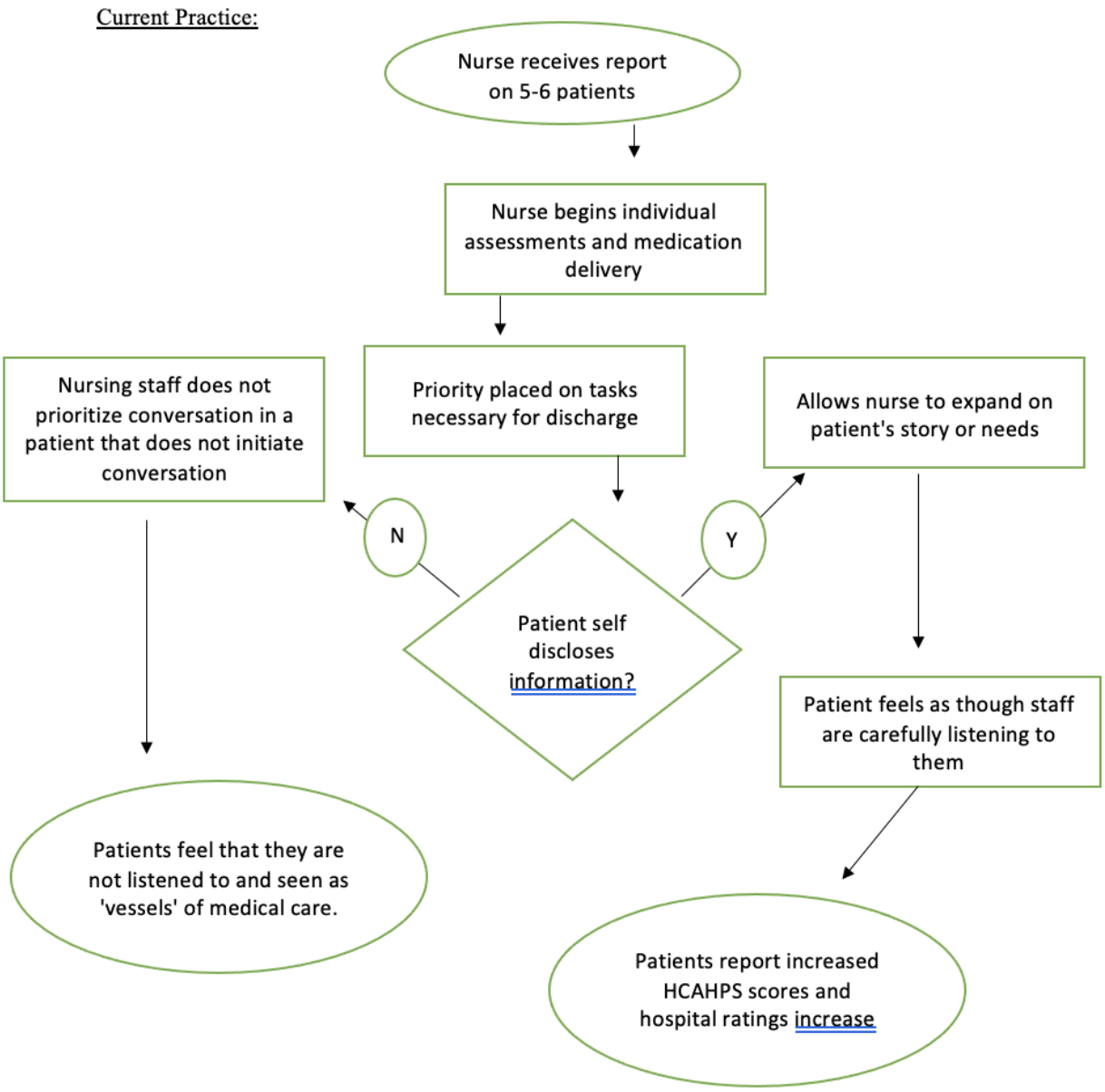


Figure 3

Current Workflow Practice



Key: Oval: start or end of process / Rectangle: a step in the process / Diamond: decision point

Figure 4

Desired Workflow Practice

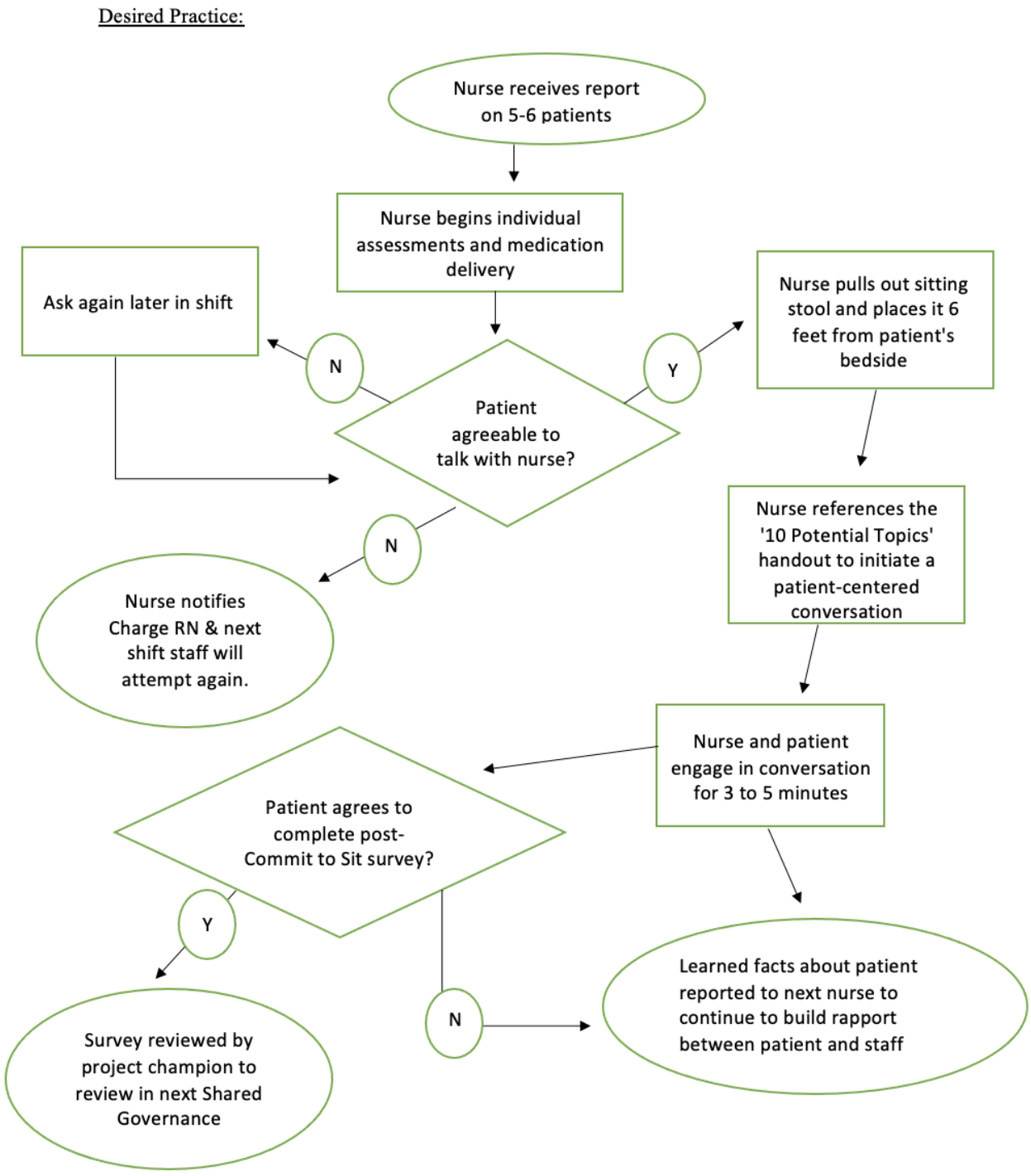


Figure 6

Communication Cheat Sheets with QR Code for Post-Intervention Survey

Figure 7

Run Chart Comparing Day and Night Shift Completion of the Intervention

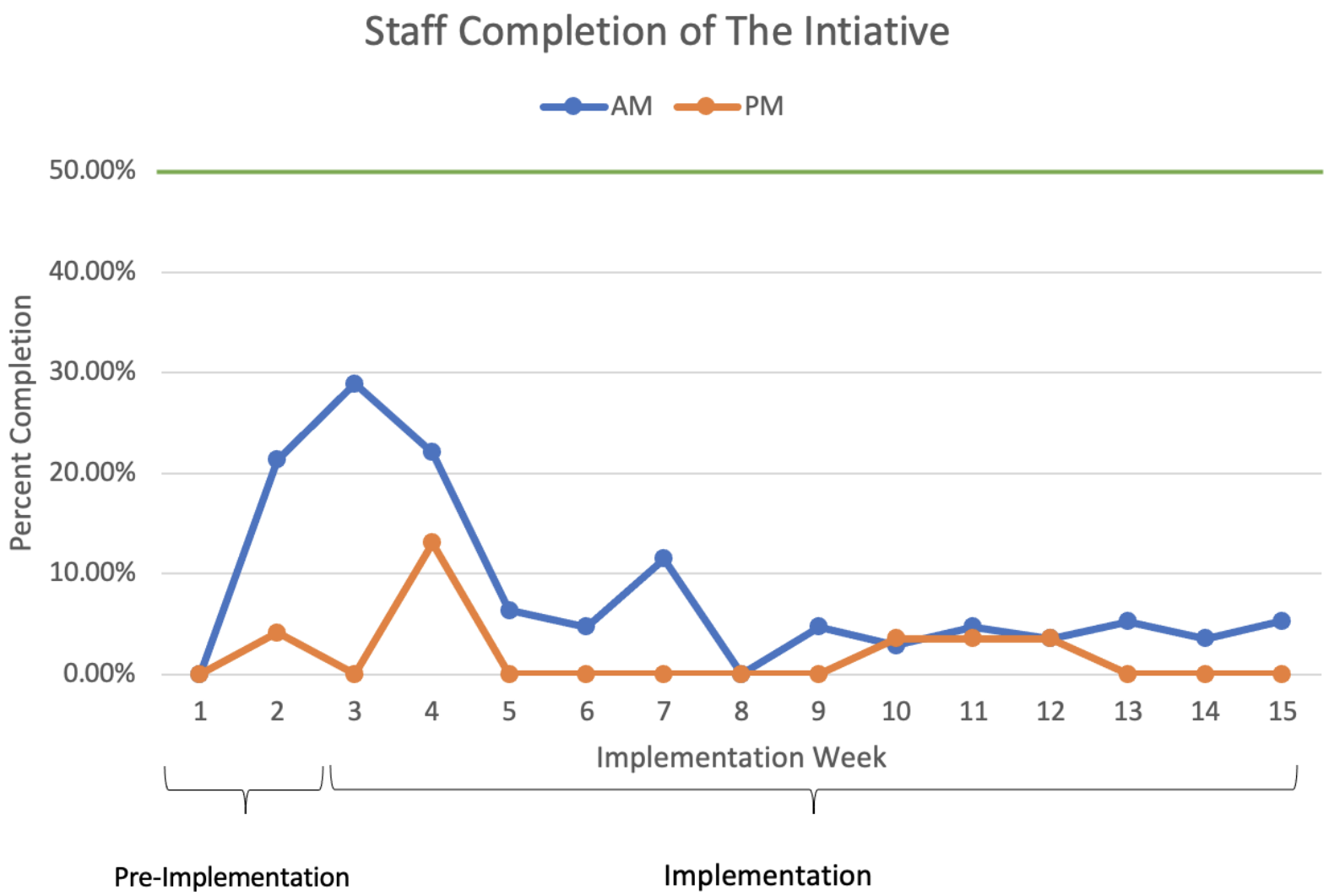
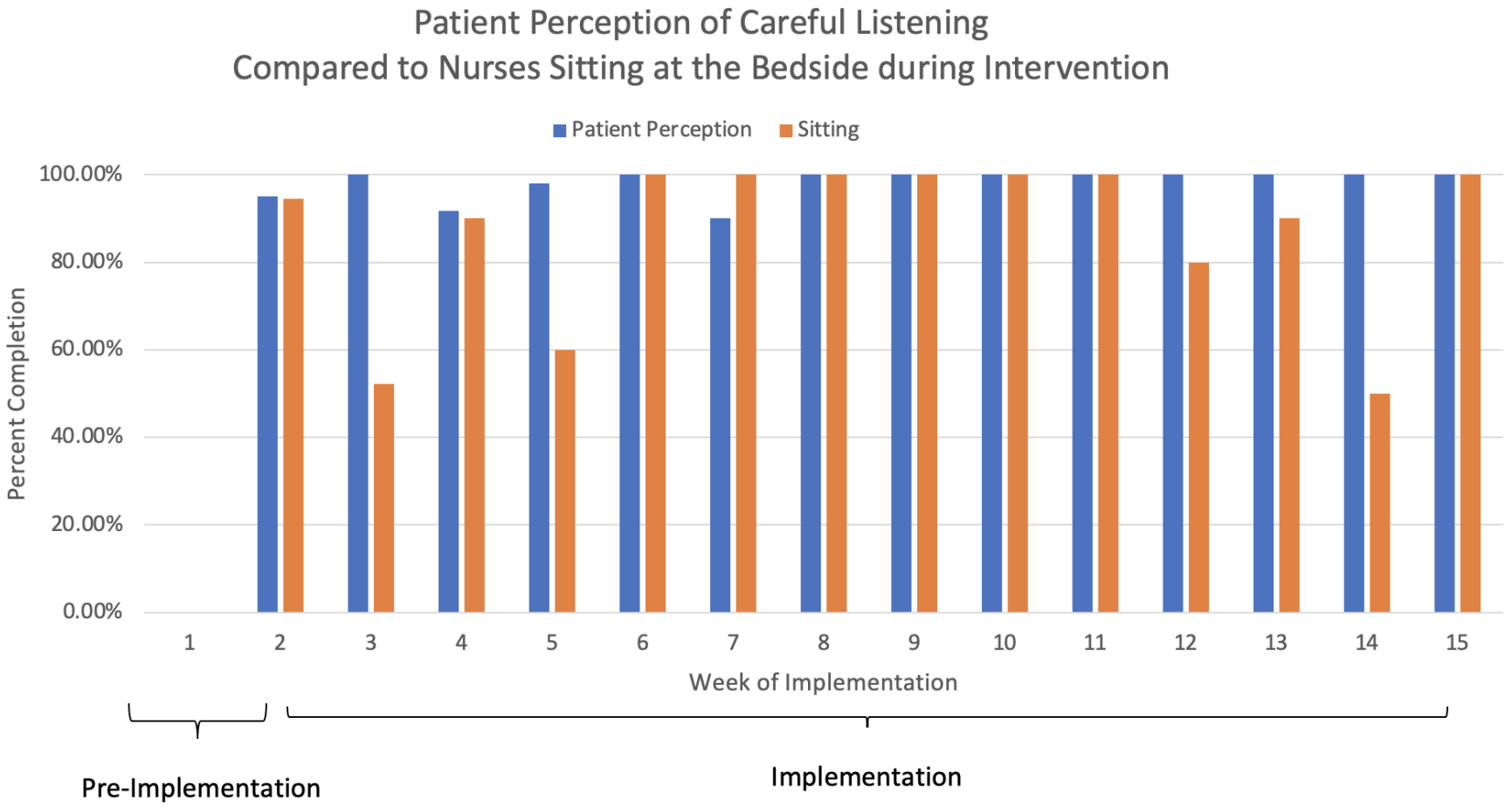


Figure 8

Patient Perception of Careful Listening when Compared to Nurses Sitting at the Bedside during Intervention



Tables

Table 1

Evidence Review Table

Citation: Adamson, K., Bains, J., Pantea, L., Tyrhwitt, J., Tolomiczenko, G., Mitchell, T. (2012). Understanding the patients' perspective of emotional support to significantly improve overall patient satisfaction. Healthcare Quarterly, 15(4), 63-69. doi: 10.12927/					**Level: III** **Quality: B**
Purpose/ Hypothesis	**Type of Evidence Research Design**	**Sample – Population, Size, Setting**	**Intervention/Procedures**	**Primary Outcome/Measures**	**Results/Conclusions**
The purpose of this study was to investigate patient's perception of emotional support during their hospital stay in an Ontario community hospital.	Qualitative descriptive study	Sampling Technique: Convenience # eligible: unknown # accepted: 25 # in control: n/a # in intervention: 25 Inclusion Criteria: not mentioned Exclusion Criteria: not mentioned Power analysis: n/a Group Homogeneity: n/a	Control: No interview Intervention: Structured interviews Intervention fidelity: 40–60-minute interviews prior to hospital discharge about patients' emotional care throughout their inpatient stay	DV: Common themes among interview transcripts Reliability: not mentioned Measurement procedure: self-reported	Conclusions: 8 themes were found that convey emotional support • Empathy • Informative communication • Being present and available • Inspiration and hope • Personalization • Supportive gestures • Humor • Ambient environment. Helpful communication strategies were eye contact, smiling, staff sitting down, and physical touch when warranted.

Citation: Lidgett, C. (2016). Improving the patient experience through a commit to sit service excellence initiative. *Patient Experience Journal, 3*(2), 67-72. doi: 10.35680/2372-0247.1148					**Level: II** **Quality: B**
Purpose/ Hypothesis	**Type of Evidence Research Design**	**Sample – Population, Size, Setting**	**Intervention/Procedures**	**Primary Outcome/Measures**	**Results/Conclusions**
The purpose of this study was to improve the nurse composite score from the 9th percentile to the 60th percentile by implementing the Commit to Sit intervention in a Northeastern Texas Hospital.	Quasi-experimental nonrandomized study	Sampling Technique: Purposeful # eligible: 369 bed hospital # accepted: 19 bed medical telemetry unit # in control: n/a # in intervention: 19 bed Inclusion Criteria: n/a Exclusion Criteria: n/a Power analysis: n/a Group Homogeneity: nursing degrees ranged from 60% with their bachelors and remaining with their associates	Control: Normal nursing care Intervention: Commit to Sit Intervention fidelity: Nurses will find time to sit with each patient, provide undivided, and uninterrupted attention.	DV: Patient perception of nurse composite, courtesy and respect, listening carefully, and explain understandably scores Reliability- not mentioned Measurement procedure: Self-reported	Clinical Significance: Nurse communication composite scores increased from the 9th percentile in 2014 to the 43rd percentile at the end of 2015. Conclusions: It was found that building nurse to patient trusting and caring relationships improve the Press Ganey Satisfaction Survey scores.

Citation: Loos, N. (2021). Nurse listening as perceived by patients: How to improve the patient experience, keep patients safe, and raise hcahps scores. *Journal of Nursing Administration, 51*(6), 324-328. doi: 10.1097/NNA.0000000000001021.					**Level: III** **Quality: B**
Purpose/ Hypothesis	**Type of Evidence Research Design**	**Sample – Population, Size, Setting**	**Intervention/Procedures**	**Primary Outcome/Measures**	**Results/Conclusions**
The purpose of this study was to analyze the nurse-to-patient relationship and how it relates to adult patient perceptions of nurse-listening behaviors in an acute care setting in Southern California.	Qualitative methodology, interpretative phenomenological analysis	Sampling Technique: Purposeful # eligible: 4 eligible acute care sites # accepted: 23 participants # in control: n/a # in intervention: 23 Inclusion Criteria: 50 years and older who had experienced an inpatient medical-surgical hospital stay within the past 6 months, English fluency, and willingness to tolerate a 2 hour audio-recorded video Exclusion Criteria: diagnosis of any disease that would affect the memory Group Homogeneity: 75% were at least high school educated, almost half were married, experienced 2-20 day hospital stay, ranging from nonorthopedic surgical, orthopedic, neurologic, and medical	Control: No interview Intervention: Post-discharge interview Intervention fidelity: recorded post-discharge interviews for later analysis of patient's verbal transcription and visual impression	DV: Common themes associated with increased nurse listening Reliability: strong interrater reliability- transcripts were reviewed 4 times Measurement procedure: Self-reported	Statistical Results: • Only 57% felt heard and comforted while inpatient. • Non-listening behaviors led to condition exacerbation (44%), anger/resentment (39%), loss of trust or frustration/anxiety (35%), sense of ineffective care (30%), and feeling less cared for (26%) • 23% of respondents felt that nurses were speaking at them, instead of to them, because they were facing away or looking at the computer Conclusions: A sense of caring was found to begin with listening and being present. The act of listening was defined as making eye contact, exhibiting follow-through, personalizing care, sitting, and being proactive in the patient's care.

Citation: Merel, S., McKinney, C., Ufkes, P., Kwan, A., White, A. (2016) Sitting at patient's bedsides may improve patients' perceptions of physician communication skills. *Journal of Hospital Medicine*.					**Level: I** **Quality: B**
Purpose/ Hypothesis	**Type of Evidence Research Design**	**Sample – Population, Size, Setting**	**Intervention/Procedures**	**Primary Outcome/Measures**	**Results/Conclusions**
The purpose of this study was to test the hypothesis that physicians who sat with patients, as opposed to stood at their bedside during interactions, would perceive that their physician spent more time with them and would rate their communication skills higher.	Randomized clinical trial	Sampling Technique: cluster # eligible: 211 patients # accepted: 159 patients and 17 hospitalists # in control: 93 patients and 9 hospitalists # in intervention: 66 patients and 8 hospitalists Inclusion Criteria: newly admitted patients from 06/2014 to 06/2015, English speaking, adults who consented to their own medical care Exclusion Criteria: n/a Power analysis: not mentioned Group Homogeneity: equal male to female patient ratios, majority Caucasian patients, majority aged 60 or above.	Control: Hospitalists stood during patient interaction Intervention: Hospitalists sat during patient interaction Intervention fidelity: physicians performed their patient interview while sitting using the chair provided through the study	DV: patient perception of physician communication Reliability: not mentioned Measurement procedure: Self-reported	Statistical Results: Seated physicians were statistically more likely to receive an 'always' response to whether the patient perceived the physician listened carefully to them (p= 0.02) and if they explained things in an easy way to understand (p=0.05). Clinical Significance: - Patients did perceive that seated physicians listened more carefully and explained things in an easy way to understand more than standing physicians. Conclusions: These findings indicate that seated visits may improve patient satisfaction

Citation: Orloski, C., Tabakin, E., Shofer, F., Myers, J., Mills, A. (2019). Grab a seat!: Nudging providers to sit improves the patient experience in the emergency department. *Journal of Patient Experience*, *6*(2), 110-116.					**Level: II** **Quality: A**
Purpose/ Hypothesis	**Type of Evidence Research Design**	**Sample – Population, Size, Setting**	**Intervention/Procedures**	**Primary Outcome/Measures**	**Results/Conclusions**
The purpose of this study was to characterize an association between provider posture (sitting or standing) and patient satisfaction.	Prospective controlled pre-post, blinded trial	Sampling Technique: cluster # eligible: 109,000 # accepted: 287 # in control: 1053 # in intervention: 1774 Inclusion Criteria: 18 years or older, GCS of 15, were being discharged from the ED to home. Exclusion Criteria: presence of dementia, acute psychosis, or clinical intoxication Group Homogeneity: control participants were slightly older	Control: No use of stool. Intervention: "Grab a Seat" stools were placed in each patient room Intervention fidelity: patients were given a 4 point Likert scale survey to assess how well providers kept them informed, spent enough time with them, whether they felt listened to, and if the provider sat with them. Educational video about communication and grab a seat stools were provided as visual cues.	DV: patient satisfaction Reliability: strong test-test reliability Measurement procedure: Self Reported	Statistical Results- Providers sitting at any point of the encounter resulted in improved responses of politeness, caring, listened, informed, and timely ($p < 0.0001$). Clinical Significance: using visual cutes in the physical environment may motivate providers to sit

Citation: Swayden, K., Anderson, K., Connelly, L., Moran, J., McMahon, J., Arnold, P. (2012). Effect of sitting vs standing on perception of provider time at bedside: A pilot study. *Patient Education and Counseling, 86*, 166-171.					**Level: I** **Quality: A**
Purpose/ Hypothesis	**Type of Evidence Research Design**	**Sample – Population, Size, Setting**	**Intervention/Procedures**	**Primary Outcome/Measures**	**Results/Conclusions**
The purpose of this study was to assess patient's perception on whether the provider spends more time at the bedside if they are seated vs standing.	Prospective randomized controlled study	Sampling Technique: systematic # eligible: 134 patients # accepted: 120 patients # in control: 60 patients # in intervention: 60 patients Inclusion Criteria: elective neurosurgery patient, 18 years old, English speaking Exclusion Criteria: inability to communicate due to ventilator support or language deficit Power analysis: not mentioned Group Homogeneity: not mentioned	Control- standing at bedside during rounds Intervention- sitting at bedside during rounds Intervention Fidelity: the same research assistant timed the physician interaction with patient from entry to exit of the hospital room. Then the assistant would ask the patient their perceived length of interaction with the physician.	DV: perceived time spent in room and patient perception of sitting at bedside Reliability: strong internal consistency Measurement procedure: Observed and Self-reported	Statistical Results- A significant difference was found between patient's perceived time spent and actual time spent at bedside, in both groups ($p = 0.01$). There was no difference in physician time spent whether sitting or standing ($p = 0.93$ and 0.87 respectively). Patients reported a positive interaction when the physician sat with them ($p < 0.05$). Clinical Significance: the physician sat at the bedside for an average of 1 min and 4 secs but patients perceived he sat for 5 min and 14 secs. Conclusions: Primary hypothesis confirmed that patients perceive more time was spent when the physician sat at the bedside. Also, patients expressed more satisfaction when the physician sat. Patients felt hurried and rushed when the physician stood but listened to when he sat.

Citation: Trotta, R., Rao, A., McHugh, M., Yoho, M., Cunningham, R. (2020). Moving beyond the measure: Understanding the patients' experiences of communication with nurses. *Research in Nursing & Health*, *43*(6), 568-578.					**Level: III** **Quality: B**
Purpose/ Hypothesis	**Type of Evidence Research Design**	**Sample – Population, Size, Setting**	**Intervention/Procedures**	**Primary Outcome/Measures**	**Results/Conclusions**
The purpose of this study was to understand recently hospitalized patient's perspectives regarding their communication with nurses in Northeastern United States hospitals.	Qualitative descriptive	Sampling Technique: stratified # eligible: 432 # accepted: 49 # in control: n/a # in intervention: n/a Inclusion Criteria: recently discharged from medicine, surgery, oncology, and women's health units and above age 18 Exclusion Criteria: did not answer the phone, unable to hear, or declines to participate Power analysis: n/a Group Homogeneity: n/a	Control: current HCAHPS communication scores of 82.7% Intervention: structured interviews Intervention Fidelity: Post-discharge phone interviews using a modified HCAPHS survey including nursing courtesy and respect, careful listening, and explaining things in a way the patient could understand.	DV: patient-rated levels Reliability- not mentioned Measurement procedure: Self-reported	Conclusions: • Study participants expressed that respect and courtesy were naturally linked to careful listening. • Nurse behaviors associated with thorough communication were engagement, anticipation, responsiveness, and teaching. • Participants reported that the nurse relationship mattered the most during salient episodes such as nighttime, embarrassing moments, or painful procedures.

Table 2

Integrative Evidence Table Synthesis

Category (Level Type)	Total Number of Sources/Level	Overall Quality Rating	Synthesis of Findings
Level 1 - Experimental study · Randomized Controlled Trial (RCT) · Systematic review of RCTs with or without meta-analysis	2	B	A cluster randomized trial performed by Merel et al, 2016 found that patients rated providers more highly on listening carefully when they sat at the bedside, notably without a significant additional time burden. A prospective randomized controlled study performed by Swayden et al, 2012 found that the seated physician is perceived as more compassionate which is associated with improved patient emotional health. Swayden et al, 2012 also found that providers will not lose time by sitting at the bedside despite physician perception. These studies recommend providers sit with their patients to
Level II · Quasi-experimental studies · Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis	2	B	A quasi-experimental study performed by Lidgett, 2016 found that sitting with patients improved HCAHPS scores and patients' perception of receiving compassionate care. Orloski et al, 2019 also found that environmental cues helped providers remember to sit with their patients when performing bedside interviews or procedural explanations.
Level III · Non-experimental study · Systematic review of a combination of RCTs, quasi-experimental, and non-experimental studies, or non-experimental studies only, with or without meta-analysis · Qualitative study or systematic review of qualitative studies with or without meta-synthesis	3	B	The qualitative studies performed by Adamson et al, 2012; Loos, 2021; and Trotta et al, 2019 found that sitting with patients improved patient satisfaction scores and the importance of the nurse to patient relationship in increasing patients' perception of being listened to.
Level IV ·	0		
Level V ·	0		
Recommendations Based on Evidence Synthesis Based on the evidence reviewed, it is strongly recommended for nursing practice to include sitting with their patients and partaking in a patient-centered conversation to improve patient satisfaction scores. The recommendation includes institutions providing a chair, nurses sitting at the patient's eye level, giving the patient their undivided attention, and asking conversational questions in a slow manner.			