

# Restoring the Relationship

## *The Key to Nurse and Patient Satisfaction*

**H**ere are two simple truths. Nurses most often choose their profession because they want to provide excellent patient care. Patients trust, and most often recommend, hospitals because of the nursing care they receive. Doesn't it make sense then, as hospitals struggle to win and retain the best of both groups, that they should do all they can to ensure that relationship is the best it can be?

"Almost all the most highly correlated items on our standard patient survey—those that would make someone recommend a hospital—are driven in small and large measure by nurse attraction," affirms Deirdre Mylod, director of research and development at Press Ganey Associates Inc., a national patient satisfaction firm in South Bend, Ind. She adds that nursing care has the "greatest halo effect" in setting the tone of the care experience. "If you improved nothing else but nursing care in your hospital, it has the strong potential to set up a positive filter for the [patient] experience," she says.

Furthermore, in a recent Press Ganey study analyzing the link between patient satisfaction with hospital care and how it relates to the satisfaction of employees delivering that care, data from more than 50,000 employee satisfaction surveys and close to 20,000 patient satisfaction surveys gathered from 33 U.S. hospitals showed a strong correlation between the two, indicating that patient and employee satisfaction are clearly linked and have been so for many years, researchers stated. The connection is logical enough.

"By virtue of the fact that nurses spend the most time with patients, in that intimate relationship, [their work] is highly correlated with patient satisfaction," says Mary P. Malone, execu-

tive director of consulting services with Press Ganey Associates.

"Patients want empathy, anticipation of their needs and a personalized, humanized experience—something that nurses do every day." She adds, "Nurses clearly influence patient satisfaction, but more subtly, their ability to work with other people on the care team influences the patient's perception of the hospital. How nurses project their joys or frustrations can influence how patients feel about the things they don't see in the hospital."

As director of the employee perspectives division of Press Ganey, Monica Locker says there is no question that "employee and patient satisfaction go hand in hand," and that the determining factor in nurses' satisfaction is the extent to which they are involved in decision-making about care.

"It drives everything else," Locker says. "Nurses want to interact with their immediate supervisors, helping to set priorities, being asked for their opinion before decisions are made ... getting recognition for good ideas ... there are ongoing opportunities for improvement there."

Nurse supervisors are very busy and it often seems there is not time for nurses to ask them questions or for them to recognize staff nurses for their good work, Locker says. Many man-

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agers may see recognition or discussion as “just something more to do.” But she adds, “managers need to make time, make it a priority to ask their nurses questions and talk. They often find out too late that they aren’t available to staff ... you have to hardwire it into the organization.”

“We have to learn to think differently about our work,” says Pamela Thompson, CEO of the American Organization of Nurse Executives (AONE). “The nursing shortage will only get worse and we need to look at the future—what will patients need and how will we work?”

To frame that challenge and confront the “extremely stressful and chaotic” hospital environment, AONE has created seven guiding principles for future patient care delivery models, designed to stimulate hospital and health system conversations on changing care. In addition to learning how to access an exponentially expanding body of knowledge and technology and conducting “critical synthesis”—negotiating care across multiple disciplines and settings—the principles ask nurses to determine care in a more clearly defined partnership with the patient.

Nonetheless, the first principle states that: “The actual work of nurses will change in the future, but the core values of caring and knowledge will remain.”

## What Nurses Want

Beyond decision-making power, nurses want fairly simple things, which unfortunately they do not always get, Locker says: basic equipment that works and is well-maintained; adequate lighting and a conducive work space; and of course, more time with patients.

Physically, they want a “lift-free environment,” says Carol Ann Cavouras, R.N., and principal and senior consultant with the Labor Management Institute Inc. in Phoenix. Caring for an older and often more obese population, many nurses have back injuries from lifting patients. Moving beds and other lifting equipment are needed more than ever.

Another common frustration is the amount of time nurses spend fetching supplies, equipment or information versus time spent in the patient’s room. Repeatedly answering call buttons also causes frustration, and here Malone says, some analysis can help nurses do less running. “The three top reasons a call button goes off are ‘potty, position and pain,’” she recites from research published by the University of Wisconsin. She believes that if nurses can anticipate those three predictable “p’s,” they won’t be forced to keep trying to speed up their work—and the way to do that is to change the system through “reframing,” she believes.

If someone comes in to take blood, for example, and moves the bedside table and doesn’t put it back as the person found it, the patient may ring the call button. Leaving things as they were found would be one less “run” for the nurse. This ties into working in multidisciplinary teams, Thompson says, thinking in an overarching “organic” way rather than a linear model. “All who work with the patient are on that team; all disciplines play a key role.”

Thompson believes that technology such as the electronic medical record (EMR) and computerized physician order entry (CPOE) will be a “key leverage point” to allow a smaller workforce to spend more time with patients and less time on “managing paper instead of patients.” However, Locker says that, “Nurses are proud of new technology, but at the end of the day,

they don’t care so much about new equipment as the maintenance of current equipment.”

Cavouras agrees that technology like the EMR is necessary, but “the interfaces have to work,” she says. “We need three to five years to get EMR figured out. Right now, it’s garbage in, garbage out. You can’t computerize old processes. We need to let computers drive the way we work.”

Locker says it’s more about the “management of change than the change itself.” In other words, nurses want sufficient training and ongoing support with new technology so they will be able to really use it when it gets to the unit.

“Nurses need a system that works for them so that they can deliver the best care,” Malone says, and the obstacles to excellent care lie in processes that are broken, whether it is how patient flow works or using outside agency or traveling nurses to cover workforce shortages.

The latter is a big headache for the core nursing staff, Cavouras says. “They can be used very effectively, but the demand is so high, they often have only one year experience—the agencies want to get them out there fast.” She adds that traveling nurses are often paid as much as 50 percent more per hour than hospital staff, and even though the rate reflects an agency cut, the wage difference, combined with less job experience “creates bad feeling and a longer orientation period [for traveling nurses],” Cavouras says.

Nurses also feel thwarted by unrealistic measurements of patient census, Cavouras says. Finance department definitions of value on the patient unit or capacity often do not reflect the number of patients a nurse cares for during a shift, because of drastically shorter lengths of stay.

“As the length of stay goes down, work intensity goes up,” Cavouras says. “Decreased length of stay is the right thing to do, but patients are seen briefly and moved around to different levels of care. You don’t see the same patients in the same rooms every day or even all day.”

This creates two different patient censuses, Cavouras says, the midnight census—the traditional way of counting patients who stay overnight—and the operational census, which more accurately reflects transfers and other patient changes during a 24-hour period.

“Staff on the unit say the midnight census doesn’t tell their story—productivity looks low but it’s not what they really did—the operational census is more intense,” Cavouras says. And so is nurses’ interaction with patients.

## System Change at Ascension Health

“The nurse-patient relationship is changing tremendously,” observes Ann Hendrich, vice president of clinical operations excellence for Ascension Health, St. Louis. “Early diagnosis tools have created lightning-speed changes and [demanded] high-level decision-making for nurses. What has not changed is the [desire for] a close relationship with patients. And that’s what’s driving nurses away [from the field]: all the interruptions, poorly designed environments and complex demands.”

To attack these negative aspects of change head on, Ascension Health has created three calls to action in its strategic plan, demanding for itself health care that is safe, that works and that

“leaves no one behind.” Eight “action priorities,” formed out of those calls to action, are designed to create, by 2008, a system with no preventable injuries or deaths in any of its 67 facilities, Hendrich says. All the priorities, which include eliminating falls, pressure ulcers and nosocomial infections, are nurse driven.

“A culture of safety is aligned with patient satisfaction,” Hendrich says. “Quality and safety are integral for caregivers to be satisfied with their work ... it feeds into retention.”

She adds that patients have their own internal survey of how care is making them feel. “Patients ask [themselves] ‘Do I feel safe? Are there enough people to take care of me? Does this environment make me feel like an individual with respect for my privacy? Does the nurse understand my needs?’ Many of our goals are based on the patient-caregiver relationship and clinical excellence.”

Lee White, CEO of Main Line Health, Bryn Mawr, Pa., knows how it feels to ask those questions firsthand. After his own patient experience last year, he was inspired to appoint himself “chief patient safety officer” at his system, realizing the connection between safety and satisfaction, for both staff and patients.

“When I was a patient, it reinforced my concern about factors that contribute to mistakes and errors,” White remembers. “My nurse was reassigned on the second shift. The first nurse had important information on me ... but that rapport was broken” [when the new nurse came on]. He asked his new nurse if she knew all the information the first nurse had about him and she did not. A phone call remedied the situation, but it was a wake-up call to White.

[Staffing changes] “create a lot of anxiety,” White says. “It’s a big dissatisfier for nurses, not good for patients and an opportunity for errors.” He saw how a budget decision to move nurses from less busy to more busy areas during their shifts (i.e., “flex staffing”) was not a well-thought-out patient care decision and that it interrupted the continuum of care.

Cavouras advises that scripts, or checklists for patient hand-offs within or between units need to be established, where the same questions get asked every time. “Passing patients on is conducive to error,” she says. “Add in the fatigue factor and often times everything is not explained [about the patient’s care].” Physicians need to be a bigger and better part of that communication loop, as well, she adds.

“Nurses want respect from their physician colleagues,” Cavouras says. “There are a few doctors out there who are rude to nurses. A younger (under age 40) nurse will allow a doctor to [talk to her rudely] only once.” But she adds that tense and, therefore, often hesitant communication is a long-standing nurse-physician problem. “If communication is blocked or resented, the environment is less safe,” Cavouras says. “There has to be a team approach. Physicians can’t get angry for being asked questions.”

To advocate for their staff, make sure physician communication is happening, and to have a more concrete sense of staff satisfaction, there is no substitute for solid, visible nurse management.

“We see a lot more stepping up to the plate with nurse leaders making rounds,” Malone says. “They look at what’s happening for each patient and each nurse. If they are actually out on the unit, it makes for better retention and better relationships with their nurses. They can check on patients and their families, on complaints, and get them resolved more quickly.”

## Pilot Program: First Touch

In a potentially revolutionary approach to changing the dynamic on the nursing floor, Lolma Olson, president of Sage Consulting, Novato, Calif., has created (and copyrighted) a nursing care initiative she calls First Touch.

Described as “a nurse-driven process that enables the nurse to make a quick and deep connection with the patient,” eight nurses in the cardiac care unit of St. Joseph Health Center, Kansas City, Mo., were the self-dubbed “pioneers” of First Touch in November 2002.

First Touch is defined as the initial nonclinical, personal contact each nurse has with each of her patients, beginning and ending her shift with a simple hello and goodbye—entering their rooms without any equipment (“armor” as some nurses have referred to it)—and not performing any tasks until she has connected one-on-one with each individual.

The point is to “be present each time you come in,” Olson says, making eye contact and asking each patient how they are before anything else is done. At the end of her shift, the nurse lets each patient know she is leaving and who is taking over. This is also done during any transfers during the shift.

“By going in as themselves, one person to another, it breaks down barriers,” Olson says. “The [St. Joseph] nurses say it was the hardest, but the best thing they’ve done.” Each pioneer has since mentored five colleagues, and Olson says that while several nurses were ready to leave health care before the First Touch pilot program, they will now stay, saying that the meaning of their work has completely changed—and so have patient satisfaction scores.

In the fourth quarter of 2003, patient satisfaction with their nurses’ courtesy and friendliness was 77 percent—up from 41 percent in the second quarter. Promptness in answering call lights went from 18 percent satisfaction to 68 percent, and attention to personal needs had a 75 percent satisfaction score after First Touch, as opposed to 20 percent before the program.

Although some nurses were initially worried it would take too much time, this has not proven true. “It actually saves nurses’ time,” Olson says. “By being more present, there are not as many problems—and not as many mistakes.” Nurses also found they could plan time for First Touch by setting up all their materials outside the room before they went in. “You can think of it the same as implementing any technical procedure,” Olson says.

Call light usage has gone down since First Touch’s implementation, and patients and family members come out to the nursing station less frequently, which Olson believes reflects less anxiety over their care.

“Communication is better, so the patient doesn’t have to be so vigilant about his own care. They know they can trust,” Olson explains. Pleased with its success, St. Joseph’s parent organization, Carondelet Health, owned by Ascension Health, started rolling out First Touch to all three Carondelet System hospitals this past July, with the goal of having a dozen nursing units using First Touch by March 2005.

## Talk to Me

This program and others show that creating and restoring patient and nurse satisfaction boils down to good communication.

“The successful organizations we’ve seen have taken the art of listening and following up very seriously,” Locker says. “The single biggest thing that has [made an impact on] organizations’ [satisfaction] is senior leadership coming to the unit. They see the challenges and what the technical needs are—something can be done immediately.”

By interfacing one-on-one on the unit, and asking three simple questions: “What do you need?” “What’s working?” and “What’s not working?” Locker says nurses will “feel compelled to share their thoughts—now someone owns that [information] because the leader is responsible to respond. To ask and follow up makes a tremendous impact.” But she adds that to do nothing with information received, is the worst thing leaders can do—and they will likely lose staff as a result.

Trustees should make rounds and ask these same questions, but to avoid getting into management issues, they should report to the CEO any story they hear and take an informal poll. “Ask all nurses about a problem and see what the wider story is,” Locker says. “What you are really seeking is an open dialogue

for ongoing conversation, top to bottom and bottom to top.”

Locker adds that it is important to be honest with nurses about what you can and cannot do to make changes. “Tell them the brutal facts,” Locker says. “[Say] ‘This is our reality’ and ask them for their suggestions. Create an open floor ... this makes them comfortable ... then they are playing a hand in change.” Cavouras adds: “If management can be honest and open with issues and share their monthly financials, we will have a workforce that is engaged and committed.”

Ultimately however, it’s about getting past the numbers and connecting with the people behind them. “We need to focus more on the patient experience rather than patient satisfaction,” Thompson says. “That is much deeper than the questions on a survey, and we are all responsible for that wherever we are.” Olson adds, “Relationships are the heart of the matter—we’re in the relationship business.” **T**

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