A BRIEF INTERVENTION TO IMPROVE EMOTION-FOCUSED COMMUNICATION BETWEEN NEWLY LICENSED PEDIATRIC NURSES AND PARENTS

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Abstract

Mark J. Fisher

A Brief Intervention to Improve Emotion-Focused Communication Between Newly Licensed Pediatric Nurses and Parents

Parents have increasingly participated in their children's bedside care. Parental participation has led to more provider-parent interactions and communication during such stressful events. Helping parents through such stressful events requires nurses to be skilled communicators. Brief methods of training emotion-focused communication with newly licensed nurses are needed, but as yet are rare. The purpose of this study was to evaluate the impact of a validated brief communication (Four Habits Model) training program for newly licensed pediatric nurses. The intervention focused on ways to improve nurses' emotion-focused conversations with parents. Information processing and Benner's novice to expert informed this study. The intervention is based on the four habits model, with "habits" providing a structure for nurses to organize their thinking and behavior during emotion-focused conversations with parents. Thirty-five pediatric nurses with 0–24 months of nursing experience at a large mid-western children's hospital participated in the study. Mixed methods provided data for this experimental study, using a group-by-trials repeated measures ANOVA design. Participants randomized to the intervention group participated in a one-hour three-part training: adapted four habits model content, simulated nurse-parent communication activity, and debrief. Participants randomized to the control group observed a one-hour travel video. Key outcome variables were Preparation, Communication Skills, Relationships, Confidence, Anxiety, and Total Preparation. Compared with the controls, the intervention group improved

significantly in the following areas: Preparation, $F(1,33) = 28.833$, $p < .001$; Communication Skills, $F(1,33) = 9.726$, $p = .004$; Relationships, $F(1,33) = 8.337$, $p = .007$; Confidence, $F(1,33) = 36.097$, $p < .001$; and Total Preparation, $F(1,33) = 47.610$, $p < .001$. Nurses' experience level had no effect, with the exception of Anxiety. Nurses with more experience (≥ 12 m) showed a greater reduction in Anxiety, when compared to nurses with less experience (< 12 m), $F(1,31) = 5.733$, $p = .023$. Fifty-two percent of the nurses involved in the intervention later reported specific examples of implementing the four habits when working with parents in clinical settings. A one-hour four habits communication-training program is effective in improving newly licensed nurses' preparation for emotion-focused conversations with parents.

Marion E. Broome, Ph.D., Chair

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List of Abbreviations

AIDET	Acknowledge, Introduce, Duration, Explanation, and Thank you
IUPUI	Indiana University–Purdue University Indianapolis
OUHSC	University of Oklahoma Health Sciences Center
PERCS	Program to Enhance Relational and Communication Skills
PI	Principal Investigator
RN	Registered Nurse
SBAR	Situation, Background, Assessment, and Recommendation

CHAPTER ONE: FOUNDATION AND RELEVANCE

Communication is an integral part of pediatric health care involving a constant exchange of information between providers, patients, parents, and other family members. An estimated 2,000,000 children under the age of fifteen are hospitalized at least once in the United States in one year, with an average length of stay of four and a half days (DeFrances, Lucas, Buie, & Golosinskiy, 2008; National Center for Health Statistics, 2009). In 2006 it was estimated that over 300,000 children under the age of eighteen in the United States were admitted to hospitals two or more times (National Center for Health Statistics, 2009). A child's hospitalization is a stressful experience for parents and families (Board & Ryan-Wenger, 2000, 2002; Dudek-Shriber, 2004) and stress often results from parents' quest for information and a sense of certainty (Aite et al., 2006; Corlett & Twycross, 2006), the hospital's visitation limitations (Dudley & Carr, 2004), parents receiving bad news (Gough, Frydenberg, Donath, & Marks, 2009; Price, McNeilly, & Surgenor, 2006), parents' involvement in care-related decision-making (Copnell, 2005; Coyne, 2006; Pongjaturawit, Chontawan, Yenbut, Sripichyakan, & Harrigan, 2006), and limited provider-parent collaboration (Espezel & Canam, 2003). Emerging emotions such as fear, helplessness, anger, and uncertainty, and behaviors reflecting a lack of ability to cope with bad news (Diaz-Caneja, Gledhill, Weaver, Nadel, & Garralda, 2005; Griffin, 2003b; Jackson et al., 2007; Wills & Wills, 2009) can create challenges that affect provider-parent communication. Ideally, provider-parent communication would involve shared knowledge and perspectives creating a synergistic effect that facilitates optimal patient care through strong provider-parent relationships and partnerships.

Vigilant care and clear communication are expectations for both parents and health care providers. Provider-parent communication involves negotiation (Corlett & Twycross, 2006); acknowledging, addressing, and attempting to meet parent's needs (Avis & Reardon, 2008); collaboration between providers and parents (Hammond & McLean, 2009); the provider's consideration of parent's perspectives (Ammentorp & Kofoed, 2010); and inclusion of parents in care, in interpersonal relationships, as well as providers really listening to parents (Fisher & Broome, 2011). Ineffective or poor nurse-parent communication, on the other hand, can lead to inadequate pain control (Simons & Roberson, 2002) and even more adverse outcomes (King, 2009). In her book *Josie's Story,* Sorrel King (2009) describes the outcome of poor communication between a parent, nurses, and physicians ultimately leading to the death of her youngest child. King declared, "Josie died because you all didn't listen" (King, 2009, p. 63); "she died because you did not listen to me" (King, 2009, p. 65). Focused and conscientious communication consistently carried out by nurses using fundamental communication skills and associated behaviors could help nurses communicate more effectively with parents during emotion-laden situations.

Parents are often the contact and spokesperson for hospitals to use when measuring the quality of care of their child's hospitalizations. Parents' satisfaction increases when providers' communication is considered to be high quality (Ammentorp, Mainz, & Sabroe, 2005, 2006). The current emphasis on service, patient and parent satisfaction, and the importance of nurses' courtesy, respect, listening, and provision of information are apparent in measures such as those of the Hospital Consumer Assessment of Healthcare Providers and Systems (Centers for Medicare & Medicaid Services, 2011;

Studer Group, 2010). Nurses are in a unique position to capitalize on partnering opportunities with parents because of nurse's integral role in pediatric patient care. Communication between nurses and parents is an essential part of pediatric inpatient care; however, the methods used to teach nurses about how to communicate with parents are not clear.

Description of the Problem

Communication training for nurses focused on pediatric patients and their developmental stages are part of traditional nurse training, education, and orientation programs (Gilbert, 2004; Kameg, Mitchell, Clochesy, Howard, & Suresky, 2009; Rosenzweig et al., 2008). Yet, it is not known when nurses learn how to communicate with parents, particularly in situations when parents verbally or nonverbally convey distress and intense emotions. Communicating with parents can be one of the most challenging aspects of pediatric care (Bidmead & Cowley, 2005; Fisher & Broome, 2011; Lee, 2007; Reid, Bramwell, Booth, & Weindling, 2007). Communication is a therapeutic tool comprised of an essential set of skills integral to quality nursing; however, development of these skills is often lacking in nursing education (Fallowfield, Saul, & Gilligan, 2001; Ustun, 2006). Additionally, these types of communication training programs are rare (Browning, Meyer, Truog, & Solomon, 2007; Fisher, Taylor, & High, 2012; Meyer et al., 2010) and infrequently noted in the literature, or non-existent.

Purpose of the Study

The purpose of this study was to evaluate the impact of a brief communication training intervention for newly licensed pediatric nurses intended to increase their knowledge and improve their preparation for emotion-focused conversations with parents. The intervention used in this study builds on the author's foundational work over the last three years involving undergraduate nursing students and parents (Fisher et al., 2012). Emotion-focused conversations are conversations between nurses and parents where parent's emotions are the center of attention typically requiring the nurse to address the expression of emotions first prior to delivering information or other content. Failure to address the parent's emotions could lead to an escalation of their emotional response and ultimately result in provider-parent conflict. In this study, emotion-focused conversations with parents were defined as parent-provider exchanges in which parents verbally or non-verbally express their feelings to a provider and the provider either does or does not address parents' feelings. Nurses who participated in the intervention in this study were offered a communication model, a general set of communication skills, and several strategies for approaching emotion-focused conversations with parents. It was expected nurses would use the material in clinical practice to improve communication and limit or avoid an escalation of emotions that could lead to communication breakdown.

Theoretical Framework

The frameworks used in this study include stages of nurses' professional development described by Benner, Tanner, and Chesla (2009) and information processing described by Miller (1956), Tomlinson (1981), and Greenwood (2000). These

frameworks explain how nurses new in their career have a tendency to focus exclusively on patient-care tasks and may not perceive parent's emotions as information that requires processing. If nurses fail to listen to or act on parents' expressed emotions, it interferes with nurse-parent interactions and communication. The professional development framework of Benner et al. (2009) uses the Dreyfus model of skill acquisition to describe how nurses attain skills and convey knowledge in the context of expert practice. Information processing theory provides a useful framework to describe how people handle information (Greenwood, 2000). This theory could be useful in trying to understand some of the complexities involved in emotion-focused nurse-parent conversations (Greenwood, 2000). Together, these frameworks will help to guide the brief communication intervention tested in this study and the outcomes measured to evaluate its effectiveness.

Novice to Expert

At any one time, as many as ten percent of the nurses in acute care hospitals are new graduates creating both opportunities and challenges (Berkow, Virkstis, Stewart, & Conway, 2009; Nursing Executive Center, 2007). New graduates leave their nursing programs with a myriad of different personal and professional experiences, knowledge, and technical skills. Newly licensed nurses' limited experience and knowledge are influenced by their time and attention focused on knowledge acquisition, orientation to tasks, and technical skill development (Benner et al., 2009; Linder, 2009). Familiarity with and being emotionally attuned to a situation facilitates judgment helping early career nurses to see and interpret the meaningful aspects of a particular situation (Benner et al., 2009). Unfortunately, newly licensed nurses tend to concentrate on tasks and technical

skills thus making interactions with parents when parents express emotions likely difficult. Additionally, parents' expressed emotions may produce a high level of anxiety for the nurse potentially limiting the nurse's confidence about being prepared for nurse-parent emotion-focused conversations. Anxiety about personal insufficiencies in facing clinical demands can create distance between nurses and parents making emotion-focused conversations difficult (Benner et al., 2009). Anxiety from first-time encounters involving critical situations can disable new nurses (Benner et al., 2009). The more knowledgeable or expert a nurse is depends on the amount of information he/she can process unconsciously and automatically (Benner, 1984; Benner et al., 2009; Benner et al., 1996). By providing newly licensed nurses with a set of habits useful in highly charged emotion-focused conversations, nurses could reduce their anxiety and increase their ability to process more emotion-focused information instinctively or intuitively and hence be more supportive to stressed parents.

Newly licensed nurses play an important role in health care and face many challenges that are different from nurses in other stages. Benner describes a nurse's trajectory over time using Dreyfus' model of novice to expert to describe how individuals learn skills (Benner, 1984; Dreyfus & Dreyfus, 1986; Dreyfus, 2004). Newly licensed nurses in Benner's framework are referred to as advanced beginners, one stage past the initial stage of novice (Benner, 1984). Advanced beginners come to the health care field with some skills that may or may not be tested; however, they are still limited in their experience with the skills they learned during their professional education. The human side of practice tends to become more important for advanced beginners in unexpected ways, often teaching them about how to care for patients and families in ways that they

did not experience in nursing school (Benner et al., 2009). It is through experience that beginners learn the importance of caring—it is so very important for nurses to demonstrate caring practices with the patient and their family instead of treating them like something that needs to be processed (Benner et al., 2009).

Pediatric patients and their parents play an important role in the development of newly licensed pediatric nurses. Expectations family members and patients have of their nurse inform and assist the development of advanced beginner nurses (Benner et al., 2009). Although communication with a parent or family member may be seen as an interruption, taking the time to listen and be mindful for a moment may help advanced beginners get through their tasks more efficiently with less interruptions and questions (from the parent or family member). Prioritization is a difficult task for new nurses to grasp and is influenced by their frequent anxiety and fatigue, which in turn makes it difficult for new nurses to have a sense of salience about the ongoing situations they face (Benner, 2004). Advanced beginners are typically driven by what they know how to do (i.e., physical care procedures) and what they believe or seems to be most important (Benner et al., 2009). Early in practice, new nurses tend to focus on doing things, seemingly applying blinders as they carry out their activities, thinking using a linear model, and ultimately seeing success and meaning as efficiently doing and completing the task (Duchscher, 2001). Their focus is not on the communication between parents and newly licensed nurses, instead, it is on completing the tasks and taking care of the priority issues as they see them dealing specifically with the patient's physiologic needs. Helping new nurses to be better prepared for emotion-focused conversations with parents

could positively influence patient care quality by helping family members' satisfaction in their child's care.

Early attention to learning tasks and skills during their "novice" status eventually progresses to that of the "advanced beginner," where the nurse begins to see the importance of relationships, interactions, and engages more reflectively about nursing as a practice (Benner et al., 2009). Newly licensed nurses work through pressures of time, realities of nursing often different than their original conceptions, exhaustion, thoughts about "getting out" of nursing, and eventually finding their place in nursing at the end of their first year and a half (Pellico, Brewer, & Kovner, 2009). Nurses move into the competent stage as they learn from their experience and begin to embrace the idea that they can make a difference driven by goals and plans (Benner et al., 2009). After about five months of practice, new nurses begin to differentiate their own practice from the process of interacting with others and they begin to form their own opinions about their own practice (Duchscher, 2001). Providing nurses with an opportunity to practice new communication skills useful in pediatric nursing practice early in their professional nursing development could have a positive influence on their practice.

Nurses in their first couple of years of practice are uncertain, deal with a great deal of chaos, need a supportive environment to grow and learn through positive experiences as they gain experience and manage the many challenges (Wangensteen, Johansson, & Nordstrom, 2008). Unfamiliarity with the acute care setting, concerns about making mistakes, attempts to find their place in nursing and the need for feedback are some of the challenges "millennial nurses" face in their first year of practice (Olson, 2009). Interactions with parents of children in the hospital setting may not be a primary

concern for newly licensed nurses. Instead, their interest in and focus on completing important procedures and tasks on a timely basis consume much of their energy and attention. Interestingly, newly licensed nurses often believe they exhibit the skills that reflect family-centered care. However, their limited knowledge and skills about working with and communicating empathically with families is well documented (Tomlinson, Thomlinson, Peden-McAlpine, & Kirschbaum, 2002). Newly licensed nurses are the focus for this training because they are early in their career, likely have limited experience in communicating with parents, and they may or may not have received adequate communication training during their basic nursing education. Newly licensed nurses in the advanced beginner stage tend to think differently and process information differently when compared to nurses in the proficient and expert practice stages. Nurses in the proficient stage are more likely able to interpret a set of circumstances and respond appropriately (Benner et al., 2009). Nurses in the expert practice stage are not only able to interpret and respond, they show an increased use of intuition as they interpret and respond to what they know to be relevant information (Benner et al., 2009). The immediacy of a new graduate's focus on task performance may allow concerns raised by the patient's family to drift into the background of a new nurse's focus of care (Benner et al., 2009). In this study, we will provide newly licensed nurses with an opportunity to gain valuable information and experience in managing difficult conversations with parents.

Information Processing Theory

The unique methods of learning, the focus of their attention, and general approach to tasks used by newly licensed nurses can be generalized into a specific way of

managing and processing information. Focus on the task and technical skills is important for all nurses; however, parent's emotions play a part in pediatric patient care. Stress parents endure when their child is hospitalized may bring on parents' emotions that could be addressed by nurses. Parents' uncertainty, fear, and anxiety among other emotions can be a part of the nurse-parent dialogue; however, nurses must be aware of the emotions and prepared to contend with them if this level of communication is to occur. Newly licensed nurses are forced to manage and process vast amounts of information in an efficient and meaningful manner, often for the first time. The need to better understand how individuals process information and how they solve problems led Donald Broadbent, an influential British psychologist working during World War II, to conduct human performance research (Anderson, 2000). Broadbent's examination of soldiers' loss of focus and failure to maintain attention on the task led to new methods of training. One's perception about and ability to analyze information was studied extensively by Miller (1956) and led to what is currently referred to as information processing theory (Anderson, 2000). An individual's processing and the flow of information involves a set of mental events (Greenwood, 2000; Tomlinson, 1981):

- Information is received from senses;
- Information is interpreted with the aid of knowledge and stored memory;
- Interpretations are integrated with a new goal to produce a certain response;
- The goal is realized through the appropriate action production; and
- Output behavior is used as feedback by which subsequent performance is monitored.

The method newly licensed nurses use to process information they receive (i.e., parents' expressed emotions) can only be interpreted based on their experience. They can then create new goals and responses, take the necessary action, and evaluate the outcome. The way newly licensed nurses process information is important to consider when developing communication-training methods. Newly licensed nurses may have insufficient knowledge about emotion-focused conversations, experiences, and memories to assist them with interpretation of parents' expressed emotions. The flow of information may be halted for newly licensed nurses after receiving anxiety producing information (i.e., parent's expressed emotions). Limitations in information exchange or cessation of the exchange can lead to miscommunication.

Information processing theory is anticipatory, selective, and constructive (Greenwood, 2000; Tomlinson, 1981):

- Anticipatory—cognition is guided by motives, plans, and goals;
- Selective—what is perceived as salient to a nurse's purpose at any given time determines what gets processed; and
- Constructive—knowledge a nurse stores is constructed from the interaction of what he/she currently perceives and what he/she already knows.

The newly licensed nurse could receive information (i.e., parent's expressed emotions); however, the interpretation and integration of that information may not result in intended actions or produce the intended behavior. Newly licensed nurses typically have limited or no short-term or long-term professional experiences and memories to pull from based on their inadequate knowledge about emotion-laden conversations and previous experience in working with parent's emotions. Nurses without the ability to interpret parents'

emotions (i.e., information) or the ability to integrate previous experience would likely result in the nurse ignoring or avoiding parents' emotions. Ignored or avoided emotions shared by parents could lead to potentially avoidable issues, problems, and conflicts.

Newly licensed nurses in the early part of their career, the advanced beginner stage, focus tends to be on the patient, tasks, and skill performance limiting their time and attention on the parent at the bedside. Communication between nurses and parents could be enhanced if nurses had increased knowledge, the self-efficacy to act on the importance of parents' expressed emotions, and awareness of how parents' emotions can serve as a useful form of information in patient care. The cognitive or first stage of skill acquisition involves committing to memory a set of facts relevant to the skill (Anderson, 2000). Practice and experience in the advanced beginner stage using a straightforward communication model could facilitate newly licensed nurses developing a set of habits useful in identifying, processing, and responding to parents' expressed emotions. The Four Habits Model was the communication model used in this study because it focuses on an organized way of thinking and acting that professionals can use during clinical conversations with patients (Frankel & Stein, 1999; Stein, Krupat, & Frankel, 2011). An adapted version of the Four Habits Model was used in this study where the Four Habits were (a) Invest in the Beginning, (b) Elicit the Parent's Perspective (adapted from original "Elicit Patient's Perspective"), (c) Demonstrate Empathy, and (d) Invest in the End. Goals of the Four Habits for the nurse were (a) creating rapport with parent quickly, (b) asking for and exploring parents' point of view, (c) being open to and being concerned about parents' emotions, and (d) collaborating with the parent in determining the conclusion of the conversation and next steps (Stein et al., 2011). Education focused

on the Four Habits served as the foundation of the intervention; however, experience and practice using the information provided nurses with an additional level of experience useful in applying and reinforcing the Four Habits Model content.

Newly licensed nurses entering the hospital may or may not have experience or the skill-set necessary when interacting and communicating with parents, especially emotionally laden conversations and during difficult situations involving parents' emotional responses. High-fidelity simulation and simulated experiences are being used to teach nursing students necessary skills, critical thinking, as well as methods to become clinically prepared, competent, and confident nurses (Kaakinen & Arwood, 2009; Messmer, 2008; Rosenzweig et al., 2008). Simulating nurse-parent interaction and communication using standardized parents can help early career nursing students develop basic family skills (Zavertnik, Huff, & Munro, 2010). Simulating parent-nurse communication using real parents, actors, and standardized parents to create an experiential learning experience could help newly licensed nurses gain valuable experience in how to interact with parents during a less stressful situation than those that often occur during real patient care. The introduction to and education about the Four Habits Model, in combination with practice in using the content, by newly licensed pediatric nurses in the advanced beginner stage of their career provide nurses with valuable knowledge and experience for the future when working with parents during emotion-focused conversations.

Significance of the Study to Nursing

The findings of this study will provide knowledge and understanding about the effectiveness of a brief educational intervention based on the Four Habits Model to help

nurses prepare for emotion-focused conversations with parents. A pre-existing and validated health care communication model used with physicians and patients was adapted for use with nurses and parents. The Four Habits Model, a foundation of theoretical support about information processing, and systematic training method (simulation) were used. The findings from this training program could be used to prepare nurses during their formal education as well as orientation during their early months and years in practice. Newly licensed pediatric nurses may be one of the highest at risk for problems and challenges in having emotion-focused conversations with parents. Their limited experience working with parents, lack of knowledge, and limited practice communicating with parents during emotion-focused conversations made them ideal participants in this study. The process of testing the intervention used in this study could lead to future communication training programs involving other nurses, physicians, and other disciplines.

Developing and testing a brief method to assist newly licensed nurses to learn what is important in emotion-focused conversations with parents and increase their knowledge about some of the skills helpful in communicating with parents during difficult clinical conversations could lead to positive short-term and long-term outcomes for both nurses and parents. Nurses involved in the intervention should increase their knowledge about parents' perspectives, develop their understanding about empathic communication, ultimately improve their communication skills with parents in the short-term, and increase their confidence when communicating with parents during emotion-focused conversations. For this study, emotion-focused conversations are defined: parent-provider exchanges in which parents verbally or non-verbally expressed

their feelings to a provider and the provider either did or did not address the parent's feelings.

Research Aims, Research Questions, and Hypotheses

Research Aims

The specific research aims for this study were to (a) evaluate the effects of a brief Four Habits communication training intervention for newly licensed pediatric nurses on their level of preparation for emotion-focused conversations with parents, and (b) evaluate participants' application of the Four Habits communication training in their clinical practice.

Research Question One

How effective is the Four Habits communication training in preparing newly-licensed pediatric nurses for emotion-focused conversations with parents?

Hypothesis: Nurses participating in the intervention will show a greater improvement in one or more of the five individual scores and overall preparation scores when compared to the control group. Individual scores are preparation, communication skills, establish relationships, confidence, and anxiety. Overall or total preparation scores are comprised of the sum of all five individual scores; therefore, a change in one individual score would result in an increase in overall preparation.

Research Question Two

Is there an interaction between training and amount of previous experience in nurses' preparation for emotion-focused conversations?

Hypothesis: Nurses with fewer months of experience in practice prior to participating in the treatment will show a greater improvement in their individual scores

and overall preparation scores when compared to nurses with greater months of experience.

Research Question Three

How do newly licensed pediatric nurses apply the Four Habits communication training content in the clinical pediatric patient care setting?

Hypothesis: Nurses participating in the intervention will report the use of one or more habits in the clinical setting that positively influenced their communication with parents.

CHAPTER TWO: REVIEW OF THE LITERATURE

Health care is constantly changing influenced by research, new and developing perspectives, new models of health care, and a host of additional influences. Changes in visitation rules and regulations, the introduction of family-centered care in the 1980s, and parent's presence during life-threatening events initiated in the 1990s continuing today all frequently place parents at their child's bedside. Parents provide emotional support, participate in care, and are involved in the decision-making process with their child during hospitalization. Changes in pediatric in-patient care over the last 30 to 40 years have altered patient care and in doing so, created a number of challenges for providers and parents. Changes have occurred in several areas including provider-parent interactions, provider-parent communication, and the myriad of factors that affect provider-parent communication.

Communication resulting from interactions between providers and parents plays a major role in the quality of health care. Parents accompanying their children through the hospitalization process are constantly communicating with nurses. Parents have an expectation that nurses either come with innate communication skills or learn about communication during their professional education. Unfortunately, for nurses and other health professionals, much of health care communication learning appears to occur on the job through trial and error as nurses interact with parents. Nurses learn basic communication skills during their education; however, this is not a primary focus of their preparation, and the depth and breadth of communication education and learning is not known.

This chapter presents an overview of the historical and current influences on today's pediatric health care system, how parents were viewed and treated by health professionals, and how these major influential changes have influenced parent-provider interactions. Current literature addressing the challenges of these interactions for newly licensed nurses is presented as well as a need for a simulated intervention to assist them to develop and practice skills necessary for communicating with parents during emotion-focused conversations. Research is summarized and critiqued in the following areas: (a) changes in health care, (b) parents' bedside presence, (c) parent-provider communication, (d) simulation use in communication training, and (e) the Four Habits Model.

Health Care Changes and Parent-Provider Communication

Influential health care changes during the last 30 to 40 years led to changes in patient care, interactions between providers and patients, and communication processes in health care. The more traditional view of patient care was influenced by linear or mechanical patterns of thinking, the biomedical model, and paternalism, all of which served to limit productive provider-parent discourse. In contrast, several new points of view have begun to positively influence thinking about provider-parent communication. For instance, complexity, humanism or the biopsychosocial model, and family-centered care have the potential to illuminate new solutions to some of today's health care communication challenges.

Communication between physicians and parents traditionally was hierarchical, linear, or top-down, in which physicians shared information and their knowledge with patients and family members, and patients were expected to follow along, not ask any

questions, and to accept the physicians' decisions about what the best options for care were. In their classic work in the late 1960s, Korsch, Gozzi, and Francis (1968) documented some of the major gaps in communication between parents and physicians (Gozzi, Morris, & Korsch, 1969). They found dissatisfaction was highest for parents whose expectations or worries did not receive the doctor's attention (Korsch et al., 1968). Additional barriers in communication between doctors and parents included the doctor's lack of warmth and friendliness, the use of jargon, and failure to listen to or take into account the parent's concerns (Korsch et al., 1968). Although Korsch's work is dated, many of these issues remain and communication between parents and providers continues to be less than optimal. In a recent study by Fisher and Broome (2011) some of these same themes were reiterated. Factors that are essential to effective provider-parent interactions, relationships, and communication are providers' use of an inclusive and caring approach when information is shared with parents, attention to and development of interpersonal provider-parent connections, and both providers and parents demonstrating behaviors that result in trust and respect for one another (Fisher & Broome, 2011).

New approaches, such as complexity theory and the biopsychosocial model, assist providers, patients, parents, and family members to work together in an effort to find solutions to some of the challenges in health care with the potential to achieve a higher level of care. Potential efficiencies and an increase in effectiveness could lead to high quality care and high levels of patient and parent satisfaction. However, a necessary component in health care that serves as a building block for future solutions is effective communication between providers and parents.

Linearity and Complexity

An influential model driving much of the care in our nations' hospitals previously and continuing today is the linear and mechanistic model. Traditionally, complex problems in health care were broken down to smaller and smaller pieces through deductive means with the pieces examined in an isolated counterproductive manner (Plsek & Greenhalgh, 2001). Although the machine metaphor serves as a useful model for mechanisms, it has limited application in health care (Plsek & Greenhalgh, 2001). Very few if any of the components, methods, and processes comprising pediatric health care and pediatric health care systems are consistent, independent, or predictable like machines. In the mechanistic model, communication is assumed to follow predictable and consistent rules in health care; however, this assumption does not account for all of the needs of the children and their families. Providers, patients, and family members involved in health care rarely act independently and those involved are not always consistent or predictable. Instead, messages can be lost, miscommunication and poor communication could occur, and errors can result. Using the linear and mechanistic model, people are often viewed as "unreasonable" or "resistant to change" and parent behavior is "wrong" or "inappropriate" when they do not follow expectations of health care providers (Institute of Medicine of the National Academies, 2001, p. 311). Linear and mechanical methods of delivering care can limit creativity, flexibility, and can alter one's judgment, potentially reducing the opportunity for meaningful interactions and quality communication among patients, parents, and providers.

Linear and machine-like models do not provide the necessary guidance for efficient and effective care in today's complex health care environment. It is important

for health care providers to learn how to accept and embrace unpredictability and how to respond accordingly if both recipients of care and providers of care are to approach health care from a similar point of view (Plsek & Greenhalgh, 2001). In the complex environment of an inpatient pediatric hospital, cooperative and collaborative communication between parents and health care providers is necessary. Instead of looking for linear connections to serve as the foundation for patient, parent, and provider relationships, complexity and complexity science provides a different lens that could lead to creative solutions to some of the current health care challenges (Plsek & Greenhalgh, 2001; Plsek & Wilson, 2001). Advances in technology and advanced procedures in care are important; however, health care continues to rely on human contact, interactions, and communication. Interactions among patients, family members, and providers reflect the complexities of illness, diagnosis determination, and plan and delivery of care. An understanding of both physical and psychological aspects involved in care and treatment of disease, illness, and other acute illnesses is imperative if collaborative partnerships among patients, family members, and providers are expectations.

Biomedical and Biopsychosocial

In the majority of health care settings, the model of care typically found guiding healthcare today is one which is primarily directed and driven by disease orientation, the biomedical model (Engel, 1977). The model guides much of the care in our nation as well as the educational institutions producing tomorrow's health care professionals. "The biomedical model was devised by medical scientists for the study of disease" (Engel, 1977, p. 130). Specialized medicine and divisions of hospital units providing care for patients with specific illness categories are the outcomes of the biomedical model and its

influence on health care. Definitions and descriptions of disease are the basis of the biomedical model, which create dilemmas when attempting to describe and define communication in health care using this model. Physicians and nurses socialized to think about patients' illness using the biomedical model may not find they are ready or able to deal with the complex interactive demands and related communication needs of pediatric patients today.

Emerging models and perspectives of care challenge some of the older models paving the way for new methods of care delivery and communication between patients, parents, and providers. The biopsychosocial model initially described by Engel in his seminal work in 1977 combines the best of both worlds, medical/scientific and mental/psychological, using a systems approach beginning with subatomic particles and ending with the biosphere (Engel, 1977, 1980). Humanistic or biopsychosocial health care can best be described in terms of respect, sensitivity, interest and concern for another, connections, empathetic behaviors, shared processes, and positive regard for another (Cumbie, 2001; Dellasega, Milone-Nuzzo, Curci, Ballard, & Kirch, 2007; Fenton, 1987; McCamant, 2006; Raymond, 1995; Weissmann, Branch, Gracey, Haidet, & Frankel, 2006). In their book, *Putting Patients First: Designing and Practicing Patient-Centered Care*, Frampton, Gilpin, and Charmel (2003) describe the importance of human interaction and the benefits that come from paying attention to the patients and their families' preferences and needs in the process of creating partnerships. Some benefits of the biopsychosocial or humanistic model include positive effects on patient health outcomes, better patient satisfaction about their hospital stay, nursing care, social support, the environment, their education, and personalized care (Dellasega et al., 2007;

Fenton, 1987; McCamant, 2006). Incorporating social, psychological, and cultural influences into a biopsychosocial model of care can result in safer and more effective health care. Simply treating the medical and physical needs of humans does not assist nurses and physicians to deal with a child and family's emotional, psychological, and spiritual needs during hospitalization. The humanistic or biopsychosocial model can serve as a basis for developing innovative and creative solutions involving interactions and communication among patients, parents, and providers.

Paternalism and Patient/Family-Centered Care

The paternalistic model of care in which physicians traditionally unilaterally made decisions about what was best for patients is slowly being replaced by shared decision-making and consumer-driven models of care (Roter & McNeilis, 2003; Teutsch, 2003). Physician directed methods of setting goals and making decisions based on medically defined problem areas without patient's input or assistance typically result in relationships high in physician control and low in patient/parent control (Roter & McNeilis, 2003). Decision-making and the concept of partnership in care does not exist in the paternalistic model (Charles, Whelan, & Gafni, 1999). Yet, some form of paternalism in health care exists and still pervades much of medical communication in the United States (Angeles-Llerenas et al., 2003; Butz, Walker, Pulsifer, & Winkelstein, 2007; Swenson et al., 2004) often leaving both parents and providers dissatisfied.

The introduction of family-centered care principles in the late 1980s and early 1990s altered interactions and communication between parents and providers. Previously, parents were often limited to a few visits, sometimes only allowed one visit a day, hindering communication between parents and providers (Darbyshire, 1993; Platt, 1959).

It was not until roughly thirty years ago that parents were allowed to stay with their child during the day and sleep in their child's room while in the hospital. Even when visitation rules became less restrictive and parents were able to be with their child for longer periods of time, traditional providers communication styles remained in place (Shields, Pratt, Davis, & Hunter, 2008; Shields, Pratt, & Hunter, 2006). For instance, physicians' rounds were typically held before or after parents were visiting, or the parents were asked to leave the room during rounds. Parents were not able to be at their child's side to hear current status updates and treatment plan changes most likely leaving parents anxious, in a great deal of distress, and desperate for answers to their questions. Having parents at their child's bedside does not go without its own set of challenges. The increased opportunities for provider-parent interaction and communication during rounds created a need for providers to communicate in new and often unfamiliar ways. Habits formed over years of practice were replaced with new routines and communication methods. More consistent implementation of family-centered care remains elusive (Shields et al., 2008; Shields, Pratt, & Hunter, 2006; Tomlinson et al., 2002).

Slowly, new models of care based on supportive interactions, communication, and relationships among patients, family members, and health care providers are evolving. Relationships play an influential role in improving health care delivery and coordination (Beach, Inui, & Relationship-Centered Care Research Network, 2006; Guevara et al., 2005; Lutenbacher, Karp, Ajero, Howe, & Williams, 2005; Rodriguez et al., 2008; Sherman, 2008). Important models and frameworks of health care familiar to most pediatric providers include patient- and family-centered care (Institute for Family-Centered Care, 2010; Johnson, Yoder, & Richardson-Nassif, 2006; O'Malley,

Mace, & Brown, 2006) and relationship-centered care (Beach et al., 2006; Frankel, 2004; Safran, Miller, & Beckman, 2006; Suchman, 2006; Williams, Frankel, Campbell, & Deci, 2000). The focus of these models is an emphasis upon communication and interactions. The involvement of family, emotional support of patients and family, and the reduction of patient's and family's fear and anxiety are central aspects of these models (Barry & Edgman-Levitan, 2012). Partnering and coaching are becoming more important as exemplified by questions such as "What matters to you?" in addition to "What is the matter?" (Barry & Edgman-Levitan, 2012, p. 781).

Summary Health Care Changes and Provider-Parent Communication

Health care is constantly changing requiring health care providers and parents to be flexible and able to adapt to the shifting environment. Patients and their family members are no longer satisfied with care that is provided *to/for* them without being able to provide input about their preferences and plan of care. Instead, patients, parents, and family members are interested in participating in a form of care that is provided *with* them involving collaborative relationships. Collaboration, partnerships, and communication are integral in patient-centered, family-centered, and relationship-centered care (Beach et al., 2006; Frampton et al., 2003; Shields et al., 2008). Respect, treating parents with dignity, and collaborating with parents requires strong relationships to give life to the principles of family-centered care. Collaborative relationships and partnerships among patients, parents, and health care providers can best develop as providers make concerted efforts to learn how to form these relationships and partnerships. Pediatric health care success or failure relies on countless interactions and relationships between providers and parents.

Parents' Bedside Presence and Provider-Parent Communication

Patients are the primary focus of nursing; however, the pediatric inpatient setting necessitates dual foci when parents are at their child's bedside. Although appropriate attention is directed toward the pediatric patient, nurses and other health care providers interact with parents on a regular basis, also requiring health care providers' attention. It is through these nurse-parent and physician-parent interactions that parents are involved and participate in their child's care, negotiate with health care providers, and become a part of the decision-making process.

Interactions between hospital staff and family members are characterized by discussions, information sharing, and nonverbal communication (Astedt-Kurki, Paavilainen, Tammentie, & Paunonen-Ilmonen, 2001). In their study with 320 health care providers, Astedt-Kurki and colleagues explored providers' perspectives of their interactions with patients and family members. They attempted to determine the importance of interaction, frequency, and nature of interactions, and some of the facilitators and barriers in family-provider interactions. Although interactions were reported to be "very important" by two thirds of the 165 hospital staff who responded to the survey request (81% nurses), interactions were primarily initiated by the family member. Hospital staff reported that their own behaviors (e.g., interpersonal skills 20%), openness (96%), and friendliness (96%) facilitated their interactions with family members. However, busy work schedules for hospital staff (91%), family members' apprehensiveness (78%), lack of a suitable place for discussion (63%), and the patient's illness (39%) severity were several of the barriers identified (Astedt-Kurki et al., 2001). Unfortunately, a large number of participants in the study did not respond to some of the

questions that were asked, subsequently resulting in a substantial reduction of data that was collected. Findings may have been distorted as a result.

Interactions that can lead to beneficial relationships between hospital staff and patients' families are important and can be improved through education about specific skills and attitudes (Astedt-Kurki et al., 2001). Relationships between patients and providers develop over time through identifiable stages (Thorne & Robinson, 1988). Understanding these stages and using the knowledge in care situations can facilitate the negotiation of care resulting in the goal of satisfaction for both parents and providers (Thorne & Robinson, 1988). Establishing rapport and sharing care are important elements for parents when interacting with nurses involved in their child's care (Espezel & Canam, 2003). In their study comprised of interviews with eight parents, Espezel and Canam examined the parents' experiences of nurses caring for their child in the hospital. Sharing information through a reciprocal exchange with nurses caring for their child was valued by parents (Espezel & Canam, 2003). Translation of a doctor's communication is a task nurses often provide for parents (Espezel & Canam, 2003). Doctors are looked to for their clinical competence and nurses are expected to be more skilled in interpersonal relations and caring (Espezel & Canam, 2003). Parental involvement, participation and negotiation in care, and decision-making can strengthen or test the interpersonal relations between nurses and parents. It is through these interactions and the communication process nurses and parents maneuver their way through the care process with a number of outcomes and goals in mind including quality care and satisfaction with care.

Parental Involvement

In the often emotionally charged atmosphere of inpatient pediatric care, parents search for information and look for ways they can assist, support and be involved in their child's care. Parents bring information and knowledge about their child that should be heard, respected, and appreciated by nurses and other health care providers (Brinchmann, Forde, & Nortvedt, 2002; Buford, 2005; Hutchfield, 1999). Parents' awareness of their child's temperament, response to pain and discomfort, and general knowledge about their child can be important reasons for involving parents in their child's care. Involved and vigilant parents can perform simple care tasks such as changing diapers, bathing, or feeding their child (Harbaugh, Tomlinson, & Kirschbaum, 2004; Hopia, Tomlinson, Paavilainen, & Astedt-Kurki, 2005; Power & Franck, 2008; Roden, 2005). If the supportive conditions were in place, parental involvement could increase beyond these daily activities and evolve into creating opportunities for parents to participate and contribute to the decision-making process for their child (Ygge, Lindholm, & Arnetz, 2006). In their study involving 338 hospital staff including physicians, registered nurses (RNs), and nursing support on oncology, surgery, and neurology units of three different hospitals, Ygge and colleagues examined staff perceptions of parental involvement. In general, routines in pediatric oncology for involving parents in the care of their child were perceived to be better than those on pediatric surgery and neurology units (Ygge et al., 2006). In the same study, parents' demands produced less strain on the oncology unit when compared to the other units. Allowing staff to devote more time to parents as a result of well-defined routines in the workplace for involving parents contributed to an environment conducive to less strain and parental demands (Ygge et al., 2006). When

supportive conditions are in place and actively engaged nurses have and use the interpersonal skills helpful in creating working relationships, parental involvement could increase to the point where parents were active participants in their child's care (Fisher & Broome, 2011). Recognizing parents as experts when it comes to their child can facilitate nurse-parent partnerships that can be carried out through parents' involvement in care (Betz, 2006).

Parental Participation

Parental participation is an umbrella term used to describe a number of elements in pediatric patient care where parents find themselves involved and interacting with health care providers. In their assessment of available literature, Power and Franck (2008) reported a systematic review of 21 descriptive studies addressing parent participation, needs, desires, expectations, attitudes, roles, and activities of both parents and health care provider. Based on that review, it appeared little has changed since Coyne's review of American and British parent participation. Coyne (1995) summarized a number of studies focused on parents' expectations, perceptions, and attitudes toward participation, and nurses' expectations and attitudes toward parental participation demonstrating that nurses did not appear to agree on what parent participation was or the direction it would take in the future. Barriers and facilitators to parent participation are influenced by health care professionals' actions and attitudes (Power & Franck, 2008). Both positive and negative attitudes toward parental participation continue to be held by health care providers today (Coyne, 1995; Power & Franck, 2008) which means developing a coherent summary of providers' attitudes toward parental participation is difficult. Although clear indicators about how parental participation could be facilitated in the past (Coyne, 1995) were not

described, it appears little has changed. Current literature indicates that inviting parents to participate, awareness and sensitivity to parents' needs, and providing information and teaching parents about the type of care parents could provide were identified as facilitators to support parental participation (Power & Franck, 2008). However, actually engaging health care providers to perform these activities consistently is an ongoing challenge with limited change over the last two decades.

In her hierarchical model of family-centered care, Hutchfield (1999) noted parental participation only occurs through involving the parent in meaningful ways. It is through involvement that rapport is established, the nurse-parent relationship becomes collaborative, and negotiation in care emerges. In their early work, Brown and Ritchie (1990) articulated the role that a nurse's expectations play in whether parents participate in care. Yet in one study Blower and Morgan (2000) found that differences in expectations about participation exist between parents and nurses. Unless parents are asked and their preferences and knowledge about participation is requested, nurses seem to operate based on assumptions that may be accurate or inaccurate. Providing today's nurses and future nurses with a structured experience in managing a difficult clinical conversation with a parent involving negotiation could provide them with valuable experience useful in building skills. Ultimately, the hope is that nurses armed with the knowledge necessary and the interactive skills useful in approaching parents in the care setting could facilitate parents' involvement and participation in their child's care.

Health care providers control a great deal of parental participation, as they are the ones who determine what suitable activities are for parental participation. In previous studies, nurses who worked on specialty units were significantly more accepting of parent

participation than those who worked on general care and cardiac critical care units (Daneman, Macaluso, & Guzzetta, 2003). Units where long-term relationships were the norm, such as hematology, oncology, and cardiology units, and where trusting working partnerships existed between parents and nurses, nurses were more amenable to parental participation (Daneman et al., 2003). Through their use of inclusion and exclusion strategies, nurses often control or manage a parent's participation by identifying cooperative, or "good" parents, and non-compliant or "problem parents" (Coyne, 2007).

Hallstrom, Runeson, and Elander (2002) investigated the extent parents participate in decisions and found the level of their participation was influenced by their ability to clearly explain their needs and the sensitivity of health care providers when identifying parents' needs. In their study of parental decision making, based on 130 hours of observation of 35 parents, Hallstrom et al. (2002) reported that the highest level of parent's participation in decision-making (level five using a one-five level scale) was exemplified by reciprocal parent-provider communication where parents' interests were requested and respected. Directive, or one-way, communication when professionals already made a decision without consulting parents was assessed as level one (lowest level). Open and sensitive communication helps parents express their needs involving care decisions for their child (Hallstrom et al., 2002). If providers were aware of the importance and usefulness of open and sensitive communication and equipped with the skills necessary for this level of communication, shared decision-making could be achieved.

Negotiation plays an important role in parents' participation in health care. Negotiation involves "responses where the nurse attempted to come to an agreement with

the parent(s) about how the parent(s) should behave" (Callery & Smith, 1991, p. 778). In a review of literature where 11 research articles were identified that focused on negotiation of parental roles in family-centered care, three themes emerged: whether or not negotiation occurred in practice, parental expectations of participation, and issues related to power and control (Corlett & Twycross, 2006). Nurses regulate the amount of parental participation by consciously or unconsciously controlling the information they give, support they provide, and the way they communicate with parents. Nurses who are more senior negotiate more proficiently when compared to more junior nurses. Nurses need to be proactive in their communication with parents early in their contact with the family rather than relying on or waiting for parents to bring their questions to nurses (Corlett & Twycross, 2006). However, if nurses are expected to initiate negotiation, they must be prepared and have the communication skills required for negotiating with parents. Parental involvement, participation, and negotiation in care with health care professionals are important in several areas, especially in the decision-making process, an integral part of care.

Parental Decision-making

Parents are placed in situations in which they need to participate and contribute to the process of making decisions about their child's care. In their conceptual model of parental treatment decision making, Stewart, Pyke-Grimm, and Kelly (2005) describe three context-related factors that influence parental decision making: illness factors, person factors, and relationship factors. Relationships based on trust, respect, and support between parents and providers directly influence the decision-making process which ultimately has an effect on decisional outcomes (Stewart et al., 2005). Development of

trust and respect, and being supportive depends on individual characteristics as well as the provider's ability to communicate. Being approachable, open to comments, actively seeking parent's opinions, and listening were identified as important physician characteristics, particularly helpful and appreciated by parents in treatment decision making (Pyke-Grimm, Stewart, Kelly, & Degner, 2006). Information exchange and communication were also found to be vital pieces of treatment decision making (Pyke-Grimm et al., 2006). When asking parents to participate in decisions for their child, a provider's communication skills and behavior influence the parents' willingness and their perceptions of their interactions with the provider.

In a study involving 130 parents, 86% (108/130) of the parents reported they had participated in decisions about their child's care (Tarini, Christakis, & Lozano, 2007). Previous hospitalizations influenced parents' participation. Parents with prior hospitalization experience were more likely to participate in decision-making, while younger parents seemed to be more involved in their child's hospitalization (Tarini et al., 2007). In addition, nurse-parent interaction and nurses' support and alignment with parents are also thought to influence parents' involvement in their child's medical decision-making. However, parents' self-reported preferences of involvement in decision-making and providers' preferences for parental involvement in decision-making are not always congruent. In another study involving 51 patient-nurse and nurse-parent pairs, 61% (30/51) of the nurses' perceptions did not match parents' preferences (Sobo, 2004). Sobo suggests that asking parents about their preferences about participating in decisions could be a useful starting point. Yet, nurses may or may not have the skills and confidence to take this vital first step.

Summary Parents' Bedside Presence and Provider–Parent Communication

During hospitalization, nurses and other health care providers work not only with the children in their care, but they often interact, share patient care, negotiate, and assist parents in making difficult care decisions. Interactions between parents and providers occur frequently in the pediatric setting when parents are involved with their child's care, participate in basic care needs or provide technical assistance in medical procedures, and participate in treatment decision-making. It is important to establish and maintain rapport with parents early in hospitalization. Parents not only engage in a constant quest for information about their child's illness and treatment but are also interested in participating in their child's care. Health care providers play an integral role in parents' level of involvement and participation in care, often serving as the ones with much of the power and control. Yet, decision-making involving parents depends heavily on health care providers' sensitivity to eliciting parents' needs and parents' ability to explain their needs. When a parent's needs and expectations are known, health care providers can be involved in negotiating, clarifying, and defining roles parents play in their child's health care. Having competence in the types of communication skills necessary for some of the more emotionally charged instances during these interactions is vital for nurses.

Parent-Provider Communication

Changes in health care and their influences in the last 30 years have enabled parents to be at the bedside where they can provide support for their hospitalized child. However, parental involvement, participation, and contribution in their child's health care decision-making process can create difficult conversations for parents and providers. Communication between providers and parents often involves an exchange of

information related to diagnosis and subsequent treatment. Yet, in addition to information exchanges, communication in the hospital setting can involve emerging emotions often expressed by parents during their child's hospitalization. Providers who are aware of parent's emotions and the challenges those emotions may create and who possess the communication skills to work through these situations fare better than those providers who do not.

Although parents' experiences vary, common emotional issues include fear, worry, anxiety, shock, frustration, and uncertainty (Dudley & Carr, 2004; Haines, 2005). In their investigation of the experience of 10 parents on a general pediatric unit, Dudley and Carr (2004) characterized parent's experience as "emotional upheaval." The upheaval stemmed from the parents' vigilance over the care their child received which led to emotions such as worry, fear, and anger complicated by parents' uncertainty and lack of control. The constant roller coaster of emotions makes it hard for parents. "Emotional turmoil" is another way Haines (2005) described the parent's experience when accompanying their child during hospitalization. In the study with seven parents of children discharged from a pediatric intensive care unit, Haines identified 10 themes in addition to emotional turmoil. Several of these themes included fear of death, family disruption, and loss of parenting role. The value of communication was also identified as an important aspect of care in the hospital. Nurses play a vital supportive role in open, honest, and trusting relationships when parents' ability to cope diminishes (Haines, 2005). The closeness and interconnectedness make the nurse-parent interaction so important when parents share their emotions. The focus of nurse-patient and nurse-parent communication is different from physician-patient and physician-parent communication;

however, identifying similarities may be helpful in developing communication training programs where emotion-focused provider-parent conversations are the focus.

Parents expect open, honest, factual, and frequent communications from health care providers. Parents' perception of effective communication is viewed as effective when emotional support is conveyed by health care providers (Coyne, 2006; Coyne & Cowley, 2006; Haines, 2005; Lam, Chang, & Morrissey, 2006; Neal et al., 2007; Simons, Franck, & Roberson, 2001). Patient and parent satisfaction have been found to be related to and connected with good communication in a number of studies (Ammentorp, Kirketerp, & Kofoed, 2009; Ammentorp, Kofoed, & Laulund, 2010; Ammentorp, Sabroe, Kofoed, & Mainz, 2007). Communication can be considered as an innate process or way of being and communication behaviors considered as being-in-relation are teachable (Zoppi & Epstein, 2002). Families reported that nurses who treated them with respect were aware of and sensitive to their feelings, and who listened were most helpful (Fisher & Broome, 2011; Moore & Kordick, 2006). Parents working with undergraduate nursing students have also reported the positive effects of nurses' awareness of parents' emotions, ability to listen, and respectful interaction (Fisher et al., 2012). However, for the busy and often inexperienced nurse, taking the time to understand issues from another person's perspective is often not an innate process. The constantly changing environment of inpatient health care often requires numerous interactions between parents and many health care providers.

Moore and Kordick (2006) conducted a study that included nine children with cancer and 18 parents. Sources of relationship conflict identified between parents and providers included misinterpretation or poor communication involving too much or too

little information (data conflict) as well as misperceptions or poor communication (relationship conflict), and unequal power, authority, and control (structural conflict). Misperceptions and poor communication were defined as unprofessional treatment, such as being unkind, ignored, without respect, stereotypes, and poor perceptions of the child and parent (Moore & Kordick, 2006). Limited use of basic relationship skills such as introducing oneself, calling patients and their parents by their names, and eliciting parents' perspectives as well as parents' understanding of content discussed could improve poor communication. In another study of over 100 pediatric patients in an intensive care unit, 48% of all conflicts were attributable to poor communication between parents and the health care provider team (Studdert et al., 2003). Much of the conflict and problems emerging from parent-provider communication involve behaviors that are teachable and learnable skills, such as identification and incorporation of parent's emotion in care, acknowledging parent's knowledge and understanding of their child, and listening. Poor or unsatisfactory communication from parents' or providers' perspectives could negatively influence care safety, and result in lower quality, less effective, less efficient care, and parents who are less satisfied with their child's care (Ammentorp et al., 2005, 2006). One common misconception is that parents and family members are extensions of the patient and do not require different communication skills, yet specific instruction is needed in this area for providers (Makoul, 2003). Understanding how nurses, physicians, and other providers learn how to communicate with parents when emotions are involved is the focus of the next section.

Communication Interventions: Nurses and Parents

Communication is a fundamental aspect of most, if not all, nurse education programs; however, varieties of methods are used and their success or outcomes are diverse as well. Communication and interpersonal skills in traditional nursing education programs tend to provide basic information and methods with little or no practice or demonstration (Zavertnik et al., 2010). Stressful and emotional nurse-parent communication requires novice nurses to build on the fundamental communication skills obtained during their education or orientation to practice programs (Gough, Frydenberg et al., 2009). Difficult conversations between parents and providers require, and could benefit from, the providers learning different methods of communication (Gough, Johnson, Waldron, Tyler, & Donath, 2009; Meyer et al., 2009). Difficult conversations that involve parents who verbally or nonverbally express emotions may require nurses' attention; however, nurses may not be prepared for such conversations.

The process of establishing rapport and involving parents in the care of their child has been found to positively influence effective interactions between nurses and parents (Espezel & Canam, 2003). In their study designed to examine parent's experiences with nurses, interpersonal interaction and common connections between parents and nurses were influenced by the nurse's friendliness, openness, knowledge of the child, and parent's knowledge of the nurse. Parents accompanying their children to ambulatory clinic visits revealed that rapport and shared care were influenced by parent's expectations of the nurse. Additionally, the nurses reported changing their approach when a child's condition improved or worsened. A nurse's knowledge about the child, the sharing of information between parent and nurse, and the nurse spending time with the

parent facilitated the process of rapport development. The more serious the child's condition, the less care nurses were willing to share with parents. When a child's condition improved, more care was shared with parents. Dialogue during times of transition and illness progression was an integral part of the process in which care management was transitioned. Nurses' ability to translate medical terminology and serve as mediators between parents and physicians provided opportunities to develop interpersonal skills and contributed to parents' understanding of the unique role nurses serve. Nurse-parent rapport was reported to more accurately describe parents' interactions with nurses than that which is characteristically reported in the literature as nurse-parent collaboration (Espezel & Canam, 2003). In an ideal situation, nurses would take time to become better acquainted with the child and their parents, gaining valuable experience over time, and develop the interpersonal skills necessary in establishing rapport. Unfortunately, much of the learning, practicing, and experience of interpersonal skills nurses could benefit from when interacting with parents is learned "on the job," developed over time, and not always effective.

Experience can be a good teacher. However, experience can be a poor teacher when the experience and lessons learned come at the high cost of ineffective communication for the parent or nurse. Newly licensed nurses were recently involved in an innovative program at Royal Children's Hospital in Melbourne, Australia. The program was designed to provide nurses with insight into their current communication with parents, update knowledge and communication skills, and improve confidence during difficult conversations with parents for instance, when giving bad news (Gough, Johnson et al., 2009). The innovative communication training program was based on an

adapted version of the Communication Skills Simulation Program that had been successfully used and implemented with recently-licensed medical staff and experienced nurses (Gough, Johnson et al., 2009; Gough, Roseby, & Marks, 2004). The 57 nurses between the ages of 21–50 years went through the two-stage training session. The first stage of the workshop involves a facilitator-led discussion about a videotaped conversation where a nurse helps a parent (actor/simulated parent) through a difficult situation. The second 20-minute stage involved a pair of nurses where one nurse works through a scenario with an actor/simulated parent while the other nurse observed. Communication sessions were critiqued by all three participants, including structured feedback from the actor/simulated parent. Prior to the training sessions, a small percentage of nurses (7% or 4 of 57) rated their preparation for having difficult conversations with parents adequate or somewhat adequate (5 or 6 on the 6-point Likert scale). This is contrasted with over half (53%) of the participants who felt less than adequately prepared (*adequately prepared* = 5 on the 6-point Likert scale). Additionally, just over a third (37%) reported not having any education in preparing for difficult conversations with parents. The majority of nurses (97%) reported the topic of difficult conversations with parents was either important or very important. The low of 7% of participants who felt that they were adequately or somewhat adequately prepared increased to 51%. Paired *t*-tests revealed a change in the individual's preparation from a mean of 3.31 to a mean of 4.51, which was determined to be statistically significant. Additionally, participants provided positive comments about their experience. Weaknesses of the study included use of a brief questionnaire designed specifically for the study that was based on self-report and the lack of a control group. Details about the

measure, such as its reliability and validity, were not reported. Nurses were able to gain insight about parents' perspectives and sensitivity for parents' point of view, value of listening and the use of silence, as well as the need to be open to all possibilities of parents' reactions experienced during difficult conversations about their child.

A brief experiential intervention targeted on new nurses' knowledge, communication skills, and confidence during difficult conversations with parents can potentially be effective. The effectiveness of participants' ability to maintain the skills and confidence is not known. Difficult nurse-parent conversations can be improved with the use of a simulated experience based on teachable and learnable skills. Communication in health care involves cognitive, affective, and behavioral components that require providers to be knowledgeable and experienced in all components in order to provide the highest level of care. Actors, simulated, and standardized patients are helpful in nurse communication training (Kameg et al., 2009; Kruijver, Kerkstra, Bensing, & van de Wiel, 2001; Rosenzweig et al., 2008) and the use of parent actors, simulated parents, and standardized parents may provide an effective addition to nurse-parent communication training programs to assist newly licensed nurses to gain valuable experience typically learned through trial and error over years in clinical practice as nurses progress from novice to expert (Benner et al., 2009).

Communication training programs that use experience and interaction facilitate learning that might otherwise not occur except through practice in clinical care. Simulating the interaction experience between nurses and parents using actors and standardized parents has been shown to be useful in nurse-parent communication. Parents and their role in health care are often overlooked in their importance and usefulness in

training medical personnel about provider-parent communication (Wayman et al., 2007). Wayman and colleagues (2007) developed a six-step Relational Communication Model to be used specifically in their simulation-based communication training program. A pilot-test of its effectiveness was conducted using a sample of pediatric oncology nurses. The intervention included instruction employing role-playing between specially trained parents with hospital experience using this Relational Communication Model. The six components of the Model are honesty, empathy, expertise, responsibility, commitment, and advocacy. Outcome measures included perceived self-efficacy in communication, fidelity/realism, effectiveness of training component effectiveness, and overall training effectiveness (i.e., relevance, engagement, communication skills, and ability to transfer skills). Nurses' mean self-efficacy scores were significantly improved based on pre- and post-intervention scores. Parent actors were determined to be an integral part of the study's fidelity as evidenced by 94% of the participants rating parents as realistic and 56% rating the scenarios as realistic. Component effectiveness and overall effectiveness of the training program were validated; however, weaknesses identified in the study included the lack of a control group and the small sample size. Parent actors provided a unique aspect of the training sessions that positively influenced the fidelity of the program. Although actors and standardized parents could be trained, it appears the actual responses of real parents are useful and worth pursuing in future nurse-parent communication research. Finally, medical errors can serve as a significant form of difficult conversations between nurses and parents, a useful alternative to sharing life-threatening issue or end of life discussion between providers and parents.

Communication Interventions: Multiple Disciplines and Parents

Wanzer, Booth-Butterfield, and Gruber (2004) examined links between satisfaction and patient-centered communication, satisfaction and health status, and parent's overall perception of their child's care involving physicians, nurses, and other hospital staff. Parental perceptions of nurse and physician patient-centered communication were positively correlated with reports of satisfaction with communication. Parental satisfaction related to communication with physicians was positively influenced by immediacy (nonverbal responses or behaviors), listening, and empathy. Parental satisfaction of communication with nurses was predicted by empathy. Listening and immediacy were more strongly linked to parent satisfaction than were the other patient-centered communication behaviors (Wanzer et al., 2004). Communication training should be included in nurse education linking empathy and listening, and training involving interaction such as role-playing to facilitate patient-centered communication. Adding new methods of communication training and education intended to assist nurses' preparation for adult and pediatric patient care to an already complex and inclusive nursing curricula may be difficult, yet necessary. Innovative methods to train and assist nurses currently practicing to implement patient-centered communication could positively influence the current patient care experience and parents' experiences.

Meyer and colleagues (2009) evaluated the impact of the Program to Enhance Relational and Communication Skills (PERCS), an interdisciplinary communication intervention, with physicians, nurses, social workers, psychologists, and chaplains at Children's Hospital Boston. The full-day intervention included case simulations involving difficult pediatric issues (e.g., withdrawing life-support and end-of-life),

lectures, group discussions, and debriefing sessions. Participants were given the opportunity to take part in conversations, review video clips and receive feedback, observe others, and to participate in experiential collaborative learning with others (Browning et al., 2007; Hanna & Fins, 2006; Meyer et al., 2009). Slightly less than half (43%) of the 106 individuals participated in the PERCS sessions were nurses. Participants' outcomes were measured in the areas of preparation, communication skills, establish relationships, confidence, and anxiety in relation to difficult conversations. Self-reported pretest and posttest PERCS questionnaire data revealed preparation was most likely to increase with over two-thirds of participants reporting higher level after training; communication, confidence, and anxiety had moderate levels of change (40% to 70%); and relationship establishing and maintenance were least likely to improve (Meyer et al., 2009). Four themes emerged from the qualitative follow-up questions. These themes were labeled as identifying one's existing competence, integrating new communication skills and relational capacities, appreciating interdisciplinary collaboration, and valuing the learning itself (Meyer et al., 2009). Additional communication skills learned included making introductions, beginning the conversation with the family's concerns, listening attentively, and recognizing the value of silence. Anxiety levels of most participants decreased and a deepened sense of patient and family perspectives were reported. Simulated conversation use, videotaped clips, and an interdisciplinary approach can assist health care providers learn how to communicate with patients and families more effectively in pediatric care. Although participants viewed the opportunity to be valuable, an identified weakness was the absence of a control group. Communication skills for collaborative interdisciplinary care are teachable

and learnable; however, the process of skill attainment and behavior change takes time. Similar findings in other studies have been reported (Lamiani, Meyer, Browning, Brodsky, & Todres, 2009; Lamiani et al., 2011; Meyer et al., 2010); however, these studies were conducted in the neonatal intensive care unit a very different setting for parents and also in a different country (i.e., Italy).

Results from these communication training and education programs and intervention studies appear to be promising; however, several challenges, weaknesses, and limitations were apparent requiring discussion. A number of the training, education, and research programs did not use a control or other form of comparison group in an attempt to gauge the effectiveness of the various programs (Gough, Frydenberg et al., 2009; Gough, Johnson et al., 2009; Lamiani et al., 2011; Meyer et al., 2009; Wayman et al., 2007). The variety in foci and incomplete definitions of foci creates problems when attempting to synthesize information from the various programs when planning future studies involving difficult conversations, potentially confrontational communication, giving bad news, and medical error disclosure (Gough, Frydenberg et al., 2009; Gough, Johnson et al., 2009; Meyer et al., 2009; Wayman et al., 2007). Finally, approaches in how to assist providers to learn about useful methods in managing difficult and challenging forms of communication varied among programs and lacked a unifying model of communication. Investigation of methods to develop communication training programs based on established communication models and tested using both treatment and control groups could be helpful in preparing providers for a number of difficult conversations with patients, parents, and their families.

Summary Parent–Provider Communication

Verbal and nonverbal communication plays a central role in all interactions between parents and providers in the pediatric inpatient setting. Effective communication involves open, honest, and frequent communication. Key skills necessary in effective health care providers' communication with parents involves establishing rapport, asking parents for their perspective and understanding, listening, and ending the conversation with a plan or next steps. Innovative methods of providing effective real-time team communication in the pediatric hospital settings include interdisciplinary rounds. Failure to listen to parents is one of the major problems in parent-provider communication directly affecting patient care safety and quality. Health care providers may perceive their communication to be thorough and effective; however, to be truly effective, communication must be perceived to be effective from the parents' perspective. In addition to incomplete or improperly conveying information, poor communication can lead to conflicts. Avoiding conflict and disruption in parent-provider communication is easier than trying to repair or remedy a situation already involving conflict. Technological advances in health care education have led to the development of innovative and creative methods of preparing health care providers through simulated experiences. Conflicts, problems, and challenges where communication is typically involved are created where the situation is part of a scenario. Individuals playing a specific role provide the learner with an opportunity to practice before making an attempt to work with real patients, parents, and family members. Providing learners with an opportunity to practice new knowledge where interaction plays a central part of the

process is possible with simulated experiences, potentially reducing the time the learner typically requires through work experience.

Communication Training Using Simulation and Standardized Patients

Simulation is a practical tool used to educate and train nurses, physicians, and other health care personnel in a variety of patient care areas. Although lectures provide information for students, the lecture process may not be the most helpful method in preparing nurses to participate in the complexities involved in clinical patient care (Jeffries, 2005). The term "simulator" when used in health care is "a device that represents a simulated patient (or part of a patient) and interacts appropriately with the actions taken by the simulation experience" (Gaba, 2004, p. i2). Simulation is a technique, not a technology (Gaba, 2004). Simulations are "activities that mimic the reality of a clinical environment and are designed to demonstrate procedures, decision-making, and critical thinking through techniques such as role playing and the use of devises such as interactive videos or mannequins" (Jeffries, 2005, p. 97). Users learn to think about the approaches they take and the process they go through when managing complex patient care situations—if and when simulated activities are planned effectively, used appropriately, and when combined with experience (Jeffries, 2005). Learning occurs for both those that are actively involved in the simulated process as well as those observing the simulated process (Jeffries & Rizzolo, 2006). Simulation is also commonly used with nurses in practice to train and educate (Hotchkiss, Biddle, & Fallacaro, 2002; Jeffries, 2007; Jeffries, Bambini, Hensel, Moorman, & Washburn, 2009; Lasater, 2007).

Interactions among providers, patients, parents, and families in health care require providers to be knowledgeable about effective communication and to be adept communicators. Simulation can involve the use of low-tech simulators, high-tech realistic patient simulators, and a variety of methods and tools in between these two (Ziv, Wolpe, Small, & Glick, 2003). One form of simulation that falls somewhere in between low-tech and high-tech are simulated/standardized patients: actors are trained to play the role of a patient, parent, or family member (Ziv et al., 2003). In one exploratory study using this approach, in an attempt to improve admission interviews with patients who were recently diagnosed with cancer, communication skills of nurses were examined (Kruijver et al., 2001). Conversations between nurses and actors who simulated patients recently diagnosed with cancer were recorded on videotape and reviewed to assess the balance or inequity of nurses' instrumental and affective communication. Instrumental communication involved categories that were focused on information, content, and topics specific to nursing and medicine. Affective communication categories involved categories that were focused on the mechanisms useful in building trusting nurse-patient relationships and social conversation. Fifty-three nurses' recordings were analyzed using the Roter Interaction Analysis System Instrumental utterances (medical topics) were used slightly over 60% of the time with affective (agreement and paraphrase) used the remaining 38%. Very few (6%) affective behaviors, such as showing concern, empathy or providing reassurance, were identified and patient's feelings and understanding of the situation were rarely assessed (Kruijver, Kerkstra, Kerssens et al., 2001). These findings mirror much of the conversations in health care with their focus on providing patients and their family members with information about the diagnosis, treatment, and symptoms.

Interpersonal and affective issues tend to get shunted to the side or considered only after the fact, potentially creating an interpersonal disconnect between patient and providers. It is important to provide information to patients; however, it also important to know how patients are feeling and their level of understanding of the information received from health care providers.

Didactic methods of instruction are useful for many kinds of learning; however, experiential methods are helpful in addressing the cognitive component involved in communication (Rosenzweig et al., 2008). In an effort to improve advanced practice nurses' confidence and communication during difficult conversations, Rosenzweig and colleagues (2008) targeted four areas in their program: breaking bad news, empathic communication, motivational interviewing, and communicating with angry patients. Thirty-eight acute care nurse practitioners received a brief didactic element that addressed the four targeted communication areas over the two years of the study. Standardized patients, professional stage actors, were recruited, trained, and served as patients in several communication-focused situations. Scenarios were developed by nursing faculty in collaboration with several curricular experts from the medical school. Learners' self-appraisal of their comfort level and ability to initiate difficult conversations were measured prior to and following training sessions. Significant improvements were noted in both confidence and ability in communication immediately following the sessions. Improvements were sustained as evidenced by repeated measures four months after the training. Standardized patients were specifically noted to be an integral part of the training participants found particularly useful because of the realism they portrayed as well as the feedback standardized patients provided to the participants

(Rosenzweig et al., 2008). It is important and it would be useful to find ways to emulate real conversations involving nurses when patients, parents, or family members share complex emotions. Interactions in which communication occurs in real time are not possible with written case scenarios where didactic lessons are traditionally the only method of instruction available. Instead, standardized patients and standardized parents are a potentially useful method to help nursing students and nurses working in the clinical setting to prepare for difficult conversations.

In a program for nurses and medical staff, Gough, Frydenberg and colleagues (2009) adapted the Communication Skills Simulation Program to use with graduate nurses (i.e., nurses in their first year as RNs). Participants watched a videotape of a nurse and an actor/simulated patient conducting "good communication" systematically deconstructing the steps involved. Nurses were paired and worked through a scenario for 20 minutes with an actor simulating a parent, one nurse observed, and the three nurses critiqued the conversation. Nurses were critiqued and provided feedback by the acting parent who stepped out of their parent role to provide the feedback. Communication behaviors noted by some of the nurses include: "not talking fast, sit down first, do not use abbreviations, allowing silence after giving news, be calm, and expect any reaction" (Gough, Johnson et al., 2009, p. 212). Participants increased their ratings of "very adequately" and "adequately" from a pre-program level of 7% to a post-program result of 51% immediately following the training. Practice in difficult communication situations is useful to help newly licensed nurses prepare for some of the challenging situations often encountered in patient care.

Communication and interpersonal interactions involve a set of teachable and learnable skills. Communication in health care involves cognitive, affective, and behavioral components requiring providers to be knowledgeable and experienced in all of these components in order to provide the highest level of care. Communication and interpersonal skills in traditional nursing education programs tend to provide basic information and methods without practice or demonstration (Zavertnik et al., 2010). Information-focused communication methods of communication such as Acknowledge-Introduce-Duration-Explanation-Thank you referred to as AIDET (Studer Group, 2010; Studer, Robinson, & Cook, 2010) and Situation, Background, Assessment and Recommendation or SBAR (Shannon, Long-Sutehall, & Coombs, 2011) are useful in the structure they provide for health care providers when they communicate with patients, parents, and family members. Nurse-parent conversations involve information; however, the constant contact nurses have with parents involves interpersonal interactions where parents' emotions are the focus. Although methods such as AIDET and SBAR may be effective in information-based conversations, it is not clear if these are the most effective methods for nurse-parent communication where emotions are the focus.

Communication Training Using the Four Habits Model

A careful and purposeful review and analysis of health care provider communication literature would be helpful to provide evidence-based information about useful communication methods in health care. In an extensive review of communication intervention studies intended to improve physician communication behaviors between physicians and patients, Rao and colleagues (2007) summarized communication findings involving residents, physicians, and both new and old/continuing patients. Physicians in

practice participated in brief communication interventions over a few hours or up to three days and residents typically participated in longer communication interventions over a month up to fifteen months (Rao et al., 2007). Interventions included the use of actual and standardized patients. Participants were provided with information (e.g., written instruction, lectures, case reviews), feedback, modeling (e.g., videotaped desirable communication behavior), and practice involving one or more sessions. Improvements in communication behaviors of practicing physicians or residents were noted overall (Rao et al., 2007).

Identification and use of specific research methods and models helpful in guiding physician communication education were recommendations noted by the authors. Rao and colleagues identified a number of communication behaviors useful in patient-physician communication including establish rapport, ask open-ended questions, elicit patient concerns, express empathy, and verify patient understanding (2007). Rao and colleagues (2007) also identified a weakness in the communication studies, the absence of a conceptual model to guide physicians' and patients' behaviors. The authors' reference The Four Habits Model (Krupat, Frankel, Stein, & Irish, 2006; Stein, Frankel, & Krupat, 2005), is useful in structuring patient-physician communication education. This model was thought by this investigator to be applicable for parent-nurse communication education as well.

The Four Habits Model describes the following set of behaviors: (a) Invest in the Beginning, (b) Elicit the Patient's Perspective, (c) Demonstrate Empathy, and (d) Invest in the End (Frankel & Stein, 1999, 2001). Habit 1: Invest in the Beginning is intended to help to create rapport quickly during the first few minutes of a meeting between a patient

and physician, which play an important role in trust development. Respect and efficiently obtaining information play central roles in the second habit, Habit 2: Elicit the Patient's Perspective. Habit 3: Demonstrate Empathy helps the provider get to the heart or core of the patient's concern with a focus on the emotional response of the patient. Finally, Habit 4: Invest in the End changes the focus of the interaction from information gathering to information sharing. Emphasis on the interplay of a group of communication skills and their interconnectedness (Frankel & Stein, 2001) makes the Four Habits Model a practical communication framework in health care.

The Four Habits Model has been used in communication skills training sessions with over 11,000 physicians with the Kaiser Permanente organization in more than six states over the last sixteen years (Stein et al., 2005). Early in the developmental process, informal conversations with physicians over lunch led to lectures and a needs assessment survey with 800 physicians. Survey results revealed physicians' interest in learning how to more effectively improve their communication with challenging or difficult patients (i.e., demanding or angry patients). A half-day session that involved a video-taped actor was used as a basis for communication skills' discussions with the second half of the day focused on skills helpful in managing difficult physician-patient interactions. The Kaiser Permanente Medical Group enabled many of their 5,300 physicians in Northern California to attend these initial one-day "Thriving in a Busy Practice (Thriving)" communication skills education sessions as a continuing education offering (Stein et al., 2005, p. 5). Feedback from those attending the Thriving sessions was overwhelmingly positive. With the introduction of satisfaction surveys in 1994 (member/patient satisfaction – MPS surveys), demand for the Thriving sessions also intensified.

Interpersonal skills and communication skills created a pressing need and increased enrollment in the Thriving sessions. Demand for the program led to a Communications Consultant Program initially comprised of a group of eight and increased to 56 members by 2004. With the infrastructure for training in place and the very high demand for training, the need for a simple and effective model for communication was identified. In 1996, Richard Frankel and Terry Stein designed, developed, and documented the Four Habits Model. Several forms of communication skills training involving the Four Habits Model have been offered over the years and the model is being used in a variety of ways at the Indiana University School of Medicine.

The Four Habits Model has been able to show great adaptability and use over the last fifteen years as noted in the following brief summary of evidence. After ten years of experience with the Four Habits Model in communication training with physicians, patient satisfaction scores have shown consistent increases and physicians have indicated the sessions have improved their ability to communicate with patients (Stein, 2007). Over 500 physicians attended the four-day intensive education program focused on communication skill improvement. Physicians evaluated the program to be valuable, they used empathy when listening to their patients, and patient satisfaction surveys showed significant increases in five of the seven groups between 1998 and 2004 (Stein, 2007). In addition to the Four Habits Model, The Four Habits Coding Scheme was developed and was validated as a useful and reliable tool for describing and evaluating clinician's communication behavior based on the Four Habits Model (Krupat et al., 2006). The Four Habits Coding Scheme is comprised of 23 categories rated on a 5-point scale with six rating areas for Habit 1: Invest in the Beginning, three rating areas for Habit 2: Elicit the

Patient's Perspective, four rating areas for Habit 3: Demonstrate Empathy (including nonverbal behavior), and ten rating areas for Habit 4: Invest in the End (Krupat et al., 2006). A fully-referenced monograph provides an overview of the Four Habits Model and details each of the Four Habits (Stein et al., 2011). The Four Habits Model has the potential of becoming the communication framework in physician-patient communication that Rao and colleagues described in their review (2007). Specific reference to empathy is unique in the Four Habits Model because other methods of communication such as AIDET and SBAR do not specifically identify emotions. The Four Habits Model has been shown to be useful in physician-patient medical interviews. The stressful event a parent endures when their child is hospitalized demands nurses who are adept in interpersonal communication involving emotions. The Four Habits Model could be adapted for use in nurse-parent communication training.

Health care is constantly changing in response to internal and external factors; thus, health care delivery methodologies must adjust, frequently requiring innovative and creative ways to educate professionals. Complexity, humanism, and patient- /family-centered care influence interactions and communication between parents and providers. Health care providers must be flexible and adapt to the shifting health care environment in order to provide quality health care. Pediatric care is different from non-pediatric patient care delivery—parents often accompany their child. In the emotionally charged atmosphere of inpatient pediatric care, parents get involved with their child's care, participate in care delivery, and assist in making decisions about their child's treatment. All interactions between parents and providers require verbal or nonverbal communication, a skill set in which providers may or may not be competent.

Adopting strategies to improve parent-provider communication is imperative to keep up with health care changes, customer service demands, and health care recipients' satisfaction. Technological advances have resulted in increased use of simulation in the clinical environment with both pre-professional students and practicing clinicians. Parents, actors, and standardized parents provide a powerful component in nurse-parent simulated and role-play communication training.

Newly licensed nurses are a group of nurses constantly confronting transition strain and communication competence requirements. Developing and testing a brief innovative intervention for positively influencing newly licensed nurses' interactions with parents during emotion-focused and difficult conversations would effectively address an identified need in pediatric nursing care. Providing nurses with an opportunity to practice difficult nurse-parent conversations before they encounter these emotion-focused situations will facilitate nurses' communication ability with parents. This study will inform content for future behaviorally-focused training initiatives and serve to demonstrate useful methods in conducting outcome-driven research, training, and education. A nurse's task of dealing with emotion-focused conversation with parents can be improved by understanding the process involved, approaching it as a straightforward process, and applying well established principles of communication.

CHAPTER THREE: METHODS

Design and Research Ethics

This quasi-experimental study used a groups-by-trials repeated measures ANOVA design. Participants were randomly assigned to intervention or comparison groups. Participants in the intervention group participated in a brief one-hour Four Habits communication training session. Participants in the control group observed a one-hour travel-documentary video and did not receive any form of communication training. As reported previously, emotion-focused conversations with parents for this study were defined as parent-provider exchanges in which parents verbally or non-verbally expressed their feelings to a provider and the provider either did or did not address parents' feelings. To assess the perception of participants' preparation for emotion-focused conversations with parents, each participant completed a five-item pretest questionnaire prior to the one-hour session and again immediately following the one-hour session. A follow-up survey was used to collect information approximately two weeks after participants completed the one-hour sessions. The survey asked the participants how they applied the communication training content in the pediatric clinical setting (see Appendix A: Research Design and Data Collection). Institutional Review Board approval for the study was obtained from the University of Oklahoma Health Sciences Center and Indiana University.

Setting

The study took place in the Dr. Sheila M. Crow and Dr. Richard D. Husband Clinical Skills Education & Testing Center at the OU Medical Center in Oklahoma City, Oklahoma. The Clinical Skills Education and Testing Center is a newly constructed

22,000-square-foot state-of-the-art facility with a waiting room, clinic rooms, hospital rooms, newborn, pediatric, and adult simulators, and standardized patients to simulate real clinical situations for medical students, nurses and nursing students, and learners from other disciplines. A large foyer or waiting area provided an open and inviting atmosphere for participants. Three Clinical Skills Education Testing Center conference rooms were used for pre-study orientation with others being used for control and intervention training sessions. Patient care rooms were outfitted with state-of-the art audio and video recording equipment with separate debriefing rooms useful for audio and video playback. The patient care room used for the study was decorated and made to appear like a typical pediatric patient-care room. Children's drawings were placed on the walls at the bedside, coloring books were placed in front of the child manikin in the bed, and pictures of the family were placed to provide a realistic patient care environment.

Sample

Participants were recruited from a moderately-sized urban (city population over 500,000) adult and pediatric tertiary care hospital with 555 beds. Approximately half of the beds (250 beds) in one building were dedicated to pediatric patients. Participants worked in direct patient care areas, including critical care units (i.e., pediatric intensive care, neonatal intensive care unit, emergency room/department) and non-critical care units (i.e., medical, surgical, hematology-oncology). There was an estimated pool of 150 pediatric nurses employed by the hospital who had held their RN license for less than 24 months. A total sample size of 34 nurses was determined sufficient using the following information: (a) ANOVA design in which the interaction of between-participants (group: treatment and control) and within-participant factors (repeated factor: pre and post) were

measured; (b) medium effect size *f* = .25 (Cohen, 1992), (c) alpha = .05, (d) power = .80 to .95, (e) two groups measured on two occasions, and (f) correlation among occasions of measurement = .5 (L. DeShea, personal communication, June 23, 2011; Faul, Erdfelder, Lang, & Buchner, 2007). The first 70 eligible nurses who voiced an interest and signed up to participate would serve as the convenience sample (i.e., 35 in the intervention group and 35 in the control group). The number of nurses targeted for recruitment exceeded the projected sample size to allow for participant scheduling issues, no shows, and dropouts.

Recruitment

Potential participants were informed about the study by the primary investigator (PI) through face-to-face communication with nurse directors, nurse managers, charge nurses, and practicing nurses (see Figure B1). Follow-up telephone calls and emails were also used to inform potential participants about the study. Eligible and interested nurses were asked to contact the research coordinator to register for the study. Unforeseen hospital policy issues led to a delay in recruitment and postponement of the study. The hospital's Shared Governance Council required changes in the recruitment flyer (see Figure B2). New flyers were printed with new study dates and hand-delivered to directors, managers, and nurses on the various units for recruitment of participants. Again, eligible and interested nurses were asked to contact the research coordinator to register for the study. Upon registration, the research coordinator verified potential participants' interest in participating, reviewed and confirmed nurses' understanding of basic expectations of the study, and verbally verified the nurses' post-licensure status (i.e., less than 24 months with an RN license). Potential participants were asked to provide the research coordinator with an email address and telephone number for future

contact and post-registration follow-up. Potential participants were invited to sign-up for a date and time to participate in the study. Several study days were determined based on feedback from potential participants and availability of the study location availability, feedback on "best days") and one of several sessions scheduled in the morning (i.e., 7:30 a.m. or 9:00 a.m.) or afternoon (i.e., 3:00 p.m. or 4:30 p.m.). Overall, 71 nurses completed the registration process and 35 actually participated in the study (49.2%). Some of the reasons potential participants provided for not attending the training sessions included: child care not available; work schedule (i.e., working four nights in a row, switching shifts, difficulty in functioning in the a.m. after shift); unexpected duties (e.g., shift running late); car trouble (e.g., dead battery, flat tire); illness (e.g., called in sick for shift); and hesitation in participating because training sessions were scheduled at end of the shift or just before shift.

Enrollment

After signing up with the research coordinator, participants were sent a confirmation email with an electronic version of the consent form for review. On the study date, each cluster of participants was scheduled to arrive at the skills and testing center on their selected date and chosen time to complete the enrollment process. Participants were led into a conference room where they received a brief overview of the study presented by the principal investigator (PI) and encouraged to ask questions throughout and at the conclusion. The PI reviewed the consent form and then participants signed the study consent form (see Figure B3).

Randomization

Before participants were contacted, a spreadsheet was created with predetermined time slots with ten openings for nurse participants (i.e., study time slot 7:30 a.m. to 9:00 a.m. with numbers 1 through 10). Participants 1 through 5 were assigned to the control group and participants 6 through 10 were to be assigned to intervention group. The research coordinator used a random number generator to generate multiple sequences of 10 integers to match the number of openings for participants. The randomized sequences were placed in a column next to the time slots assigning one integer to each. As participants responded and contacted the research coordinator with their selected study participation date and time, their name was entered in the next open time slot for their selected date and time. Names were placed on the list in the order they were received. On the date and time of the study, participants were selected as members of the control group when the number next to their name was 1–5 or assigned to the intervention group when the number was 6–10. On several occasions, a specific study date and time did not have the maximum ten participants; however, all of the participants who were present were assigned using the same random assignment process. The PI did not have access to participants' personal information and was not aware of participant assignment until the specific study date and time when it became necessary.

Groups: Intervention and Comparison

Intervention Group

This study investigated the effects of a brief educational intervention aimed at improving emotion-focused communication between newly licensed pediatric nurses and parents. Each set of participants randomized into the Four Habits communication-training

group (intervention) or control group. The intervention group completed a one-hour three-part training session comprised of: (a) Four Habits communication model content, (b) a simulation activity, and (c) a debriefing session (see Appendix C: Nurse/Participant Training Manual). The three-part training program consisted of the following:

1. Four Habits communication model content (20 minutes): description of the communication model's four components, instruction on how the model can be used during emotion-focused nurse-parent communication, and an evaluation checklist developed for use in evaluating the use of the communication model;
2. Simulation activities (20 minutes): participants were given an opportunity to actively participate or observe and all participants evaluated two simulated nurse-parent communication scenarios focused on parent's emotional response to a clinical situation; and
3. Debriefing (20 minutes): review of the simulated experience (content and process), review of observers' checklists and related feedback, review of the learning objectives and communication model content, and suggestions on how to apply the information in real pediatric nursing clinical situations.

Four Habits communication model content. The first 20-minute part of the Four Habits communication training consisted of an overview of the training session followed by communication model instruction, Four Habits-related content (Frankel & Stein, 1999; Stein et al., 2005; Stein et al., 2011; see Appendix D: Laminated Card for Nurses/Participants with Adapted Four Habits), suggestions on the model's use during emotion-focused nurse-parent communication, and a communication behaviors training

checklist. The communication training session was developed using the Four Habits Model and related Four Habits Coding Scheme (Frankel & Stein, 1999; Krupat et al., 2006; Stein et al., 2005; Stein et al., 2011). The Four Habits Model has been used extensively in physician-patient communication training and has been applied to nurse-parent communication for this study. The Four Habits Model provides a set of four separate, yet unified, communication behaviors. The term "habits" is used to indicate an organized method of thinking and acting during the process of a nurse-patient interpersonal exchange in the health care setting (Frankel & Stein, 1999). The Four Habits Model used in this study consists of the following four habits of communication behaviors: Invest in the beginning, Elicit the *Parent's* Perspective (original version: Elicit the *Patient's* Perspective, italics added), Demonstrate Empathy, and Invest in the End. Changes in the adapted version of the Model include the different title for Habit 2 and changing the focus from physician-patient communication during medical interviews and medical encounters to nurse-parent communication during pediatric inpatient care. Permission to us and adapt the Four Habits Model and Four Habits Coding Scheme was granted by the authors (R. Frankel, T. Stein, and E. Krupat; see Appendix K: Permissions). Permission to use the Four Habits Model was also granted by The Permanente Medical Group, Inc. in the form of a copyright license.

Simulation activities. Participants in the intervention were involved in two simulation sessions with a standardized parent. Adults generally learn best when they are active or doing something (Knowles, 1973). Educational practices used in the communication training program include the simulation facilitators' high expectations, an active learning process, and adequate amount of pertinent feedback (Jeffries, 2005). In

the wide range of simulation from low-tech to high-tech, this study used a low-tech simulation involving the use of a standardized patient (Ziv et al., 2003). A parent actor was trained to provide a realistic interaction for nurses to engage in learning about emotion-focused communication with parents (see Appendix E: Standardized Parent Training Manual).

The simulation model used to guide these activities involves teacher ("simulation facilitator"), student ("newly licensed nurse"), educational practices and adult learning principles, design characteristics and simulation (simulated conversation between nurse and standardized parent), and outcome (Jeffries, 2005; Jeffries & Rizzolo, 2006). The simulation model provided a framework to guide the simulated activities in this portion of the intervention, specifically, objectives, fidelity (realism), complexity, cues, and debriefing (Jeffries, 2005).

Objectives, fidelity/realism, complexity, and cues. Objectives were developed based on the expectations for a brief nurse-parent communication training session (Fisher et al., 2012) and Four Habits Model content. The use of standardized parents for this study, who were knowledgeable and thoroughly trained, provides fidelity and realism to the nurse-parent interactions. Standardized parents received detailed information about the study methods and underwent formal training in the application of Four Habits communication training content and process. Complexity of these sessions was very low when compared with high-fidelity computer-generated simulation technology. Nurses involved in the intervention served in the role of participant volunteer or observer. The role of the participant volunteer was to serve as the nurse involved in a simulated conversation with standardized parent. The role of the observer was to view, witness, and

evaluate the interaction and conversation between the participant volunteer and the standardized parent. Cues were prepared and ready to be provided to the nurses by the simulation facilitator if necessary during the simulated sessions. Several nurses, a communication expert (Richard M. Frankel), and a panel of parents reviewed the scenario, scripts, and cueing mechanisms prior to preparing the final version of the scenario for this study. Scenario structure and content was also informed from educational work the PI conducted during previous nursing student-parent communication training sessions (Fisher et al., 2012).

Debrief. A formal debriefing session following the simulation activity involving the review of the process, outcome, application of the scenario in clinical practice, and review of objectives provided participants an opportunity to process the information and critically think (Jeffries, 2005). Following the three-five minute nurse-parent simulated communication or its natural conclusion, the simulation facilitator led the twenty-minute debriefing session with the participant volunteers, nurse observers, and the standardized parent. The debriefing process involved open-ended question-answer-discussion sessions with nurse participants, nurse observers, the standardized parent, and facilitator; review of scenario participant and observer's Four Habits communication behaviors training checklists; and concluded with a review of the training session goal and objectives.

Control Group

Participants randomized into the control group observed a one-hour documentary travel video. Participants in control sessions were informed they would be offered an opportunity to complete the Four Habits communication training sessions after all

follow-up were collected and confirmed (i.e., approximately six weeks after the initial research sessions).

Procedures

This study began with recruitment of participants and ended with follow-up email surveys sent to participants approximately two weeks after the last participant completed the training program. Participants initiated their involvement by voicing their interest followed by their signing up to participate. Participants arrived on their selected date and time and then were led through the following sequence of events:

- Once all scheduled participants arrived at the skills and testing center on their designated training time for the scheduled sessions, they were led to a large private conference room, asked to sit for the introduction and consent review, and consent-signing process.
- Participants were addressed by the PI who provided a brief overview of the purpose of the study, appreciation for their involvement, and any questions were answered.
- The PI reviewed the consent form, participants were encouraged to ask questions, then asked to sign the consent form (see Figure B3).
- Consent forms were collected and the participants were led by the PI from the conference room to a hallway containing computers where they were greeted by the research coordinator. The PI went to another area of the skills center away from the participants, and the participants were asked to sit down at one of the computer desks to complete the initial request for information including demographics, expectations, and baseline pretest preparation for

emotion-focused conversations with parents information (see Appendix F: Program to Enhance Relational and Communication Skills Participant Pre-Questionnaire – Adapted Version [PERCS Pre-Questionnaire Adapted Version]).

- After the last participant completed their pre-questionnaire forms, the research coordinator located the PI and handed him a list of names of the current group of participants who had been assigned to intervention and control groups by the research coordinator using a randomized number generator (this was the time the PI became aware of who was assigned to which group).
- The PI led the control group participants into a room, informed them they were in the control group, asked if they had any questions, and encouraged to make themselves comfortable and watch the documentary travel video.
- The PI then left the "control room" and led the intervention group participants to a room where they were informed they were in the intervention group, asked if they had any questions, and encouraged to make themselves comfortable in preparation for the Four Habits communication training session.
- Both control and intervention sessions took place simultaneously with the research coordinator monitoring the control group and the PI training and monitoring the intervention group.
- After the control group completed their 60-minute video session, the research coordinator led the participants to the hallway containing computers where they were asked to sit down at one of the computer desks to complete the

follow-up request for information including follow-up posttest preparation for emotion-focused conversations with parents information and additional post-session information (see Appendix G: Program to Enhance Relational and Communication Skills Participant Post-Questionnaire – Adapted Version [PERCS Post-Questionnaire Adapted Version]). After completing the form the participants in the control group were finished with the on-site session and were allowed to leave the training area.

- After the intervention group completed their 60-minute training session, the PI led the participants to the research coordinator who was waiting in the hallway containing computers. The PI went to another area of the skills center away from the participants. The research coordinator asked the participants to sit down at one of the computer desks to complete the follow-up request for information including follow-up posttest preparation for emotion-focused conversations with parents information and additional post-session information (see Appendix G: Program to Enhance Relational and Communication Skills Participant Post-Questionnaire – Adapted Version). After completing the form, the participants in the intervention group were finished with the on-site session and were allowed to leave the training area.
- Subsequent training sessions were completed during the same day at the various times, and subsequent days and times until all participants completed their sessions.

- Approximately two weeks after participants completed their training sessions, participants received a follow-up email survey/request from the research coordinator (see Appendix H: Post-Intervention Follow-up Survey).

The researcher did not expect any risks to participants in this study. Occasionally, participation in role-playing, simulated and interactive learning experiences can raise issues that may be distressing or stressful for some individuals (i.e., embarrassed in not knowing what to do or how to respond during role-play activities). The researcher made every effort to create an environment low in stress and high in learning. Requests for volunteers to serve as participants during the simulated scenario were discussed and made early in the training session to reduce reluctance at the time of the simulated conversation. Additionally, the PI provided all of the training sessions and drew on his prior research experience and decade of teaching experience to create a positive learning environment.

Measurements

Each participant's perception of their own level of preparation for emotion-focused conversations was measured using PERCS Pre-Questionnaire and PERCS Post-Questionnaire adapted for this study with the author's permission (see Appendix F: Program to Enhance Relational and Communication Skills Participant Pre-Questionnaire – Adapted Version and Appendix G: Program to Enhance Relational and Communication Skills Participant Post-Questionnaire – Adapted Version; Meyer et al., 2009; E. Meyer, personal communication, August 10, 2010; E. Meyer, personal communication November 28, 2010). The PERCS Pre-Questionnaire and PERCS Post-Questionnaire were designed for use in the one-day Program to Enhance

Relational and Communication Skills training program and has been used with nurses, physicians, social workers, psychologists, and chaplains (Lamiani et al., 2011; Meyer et al., 2010; Meyer et al., 2009). The adapted five-item tool was used as a self-assessment measure of the individual's level of preparation and experience with emotion-focused conversations with parents in five areas: Preparation, Communication Skills, Relationships, Confidence, and Anxiety. The PERCS Pre-Questionnaire Adapted Version contained the following statement after question number eight asking about the participant's previous communication training that they believed had prepared them for emotion-focused conversations with parents: For this study: emotion-focused conversations with parents are parent-provider exchanges in which parents verbally or non-verbally express their feelings to a provider and the provider either did or did not address parents' feelings.

Adaptations made to the original PERCS Pre-Questionnaire and PERCS Post-Questionnaire were limited to the subject matter or focus for all of the questions. As noted, permission was granted from the author (E. Meyer) to use of the original PERCS material. The overall format and structure of the questions remained intact to maintain the questionnaires' integrity and as an attempt to preserve their reliability. The subject of the PERCS Pre-Questionnaire and PERCS Post-Questionnaire was changed from "difficult discussions with patients and their families in the pediatric intensive care unit" to "emotion-focused conversations with parents" for the adapted versions of the forms. An example of an adaptation for the first question addressing preparation is provided: (changes noted in italicized and underlined font)

- PERCS Pre-Questionnaire question: "In general, how prepared do you consider yourself to be *to have difficult discussions with patients and their families in the pediatric intensive care unit*?"
- PERCS Pre-Questionnaire Adapted Version question: "In general, how prepared do you consider yourself to be *in having emotion-focused conversations with parents*?"

The PERCS Pre-Questionnaire Adapted Version and PERCS Post-Questionnaire Adapted Version were scored on all five items individually on a five-point Likert-type ordinal scale (i.e., 1 [*low*] and 5 [*high*]). An additional step was added for this study, the development of a Total Preparation for emotion-focused conversations with parent score comprised of the total of all five-item areas for a potential high score of 25 (discussed and approved by the author, E. Meyer). The Anxiety item required reverse scoring during the data analysis process (i.e., 5 [*low*] and 1 [*high*]). The adapted PERCS forms were scored individually on all five items on a five-point Likert-type scale. In addition to the five individual items and a Total Preparation score, the PERCS Post-Questionnaire Adapted Version also contained related "yes" or "no" formatted questions. The participants were asked whether the Four Habits communication training program improved their sense of preparation, communication skills, ability to develop and maintain relationships with parents, confidence, and anxiety.

Reviews were conducted examining PERCS Pre-Questionnaire from the original study by Meyer and colleagues (2009), PERCS Pre-Questionnaire Adapted Version data from a pilot project with nursing students, PERCS Pre-Questionnaire Adapted Version data from this study, and PERCS Pre-Questionnaire from a study by Lamiani and

colleagues (2011). Results revealed similar Cronbach's Alpha values, means, and standard deviations as shown in Table 1 (nurses and non-nurses), Table 2 (nursing students), Table 3 (pediatric nurses), and Table 4 (nurses).

Table 1

PERCS Pre-Questionnaire Data—Meyer et al., 2009

PERCS item	*n*	Range	*Mean*	*SD*
Preparation	101	1–5	2.84	0.758
Communication Skills	100	1–5	3.28	0.817
Relationships	101	1–5	4.08	0.664
Confidence	101	1–5	3.01	0.824
Anxiety	101	1–4	3.01	0.787
All PERCS items Total Preparation	101	5–23	16.21	2.988

Note. Cronbach's coefficient alpha: 0.817.

Table 2

Pilot Project PERCS Pre-Questionnaire Adapted Version Data

PERCS item	*n*	Range	*Mean*	*SD*
Preparation	11	1–3	2.18	0.603
Communication Skills	11	2–4	2.86	0.777
Relationships	11	2–5	3.36	0.809
Confidence	11	2–4	2.72	0.786
Anxiety	11	1–4	2.81	0.981
All PERCS items Total Preparation	11	10–19	13.90	2.773

Note. Cronbach's Alpha: 0.781.

Table 3

Dissertation Study PERCS Pre-Questionnaire Adapted Version Data

PERCS item	*n*	Range	*Mean*	*SD*
Preparation	35	1–4	2.83	0.747
Communication Skills	35	2–4	3.14	0.733
Relationships	35	2–5	3.66	0.684
Confidence	35	2–4	2.74	0.741
Anxiety	35	2–5	3.49	0.781
All PERCS items Total Preparation	35	11–23	15.86	2.819

Note. Cronbach's Alpha: 0.797.

Table 4

PERCS Pre-Questionnaire Data —Lamiani et al., 2011

PERCS item	*N*	Range[a]	*Mean*	*SD*
Preparation	54	–	2.76	0.845
Communication Skills	54	–	3.33	0.752
Relationships	54	–	3.39	0.627
Confidence	54	–	3.44	0.604
Anxiety[b]	52	–	2.63	0.841
All PERCS items Total Preparation	–	–	–	–

Note. Cronbach's Alpha: not available/not provided.
[a]Range values were not provided. [b]It was not clear if the pretest anxiety score was reverse scored.

Data Analysis Plan

Research Question One

How effective is the Four Habits communication training in preparing newly licensed pediatric nurses for emotion-focused conversations with parents?

Hypothesis tested: Nurses participating in the intervention will show a greater improvement in one or more of the five individual scores when compared to the control group. Data points: Mean Preparation score, Communication Skills score, Relationships score, Confidence score, and Anxiety score; and mean Total Preparation score (combination of all five scores). Source of data: PERCS Pre-Questionnaire Adapted Version (items/questions 11–15) and PERCS Post-Questionnaire Adapted Version (items/questions 2, 4, 6, 8, and 10). Analysis tests/processes: *F* test for the main effect of training followed by multiple comparisons ($p < .05$).

Research Question Two

Is there an interaction between training and the amount of previous experience in nurses' preparation for emotion-focused conversations?

Hypothesis tested: Nurses with fewer months of experience in practice prior to participating in the treatment will show a greater improvement in their individual and Total Preparation scores when compared to nurses with greater months of experience. Data points: Mean Preparation score, Communication Skills score, Relationships score, Confidence score, and Anxiety score; and mean Total Preparation score (combination of all five scores); and number of months of experience with RN license. Source of data: PERCS Pre-Questionnaire Adapted Version (items/questions 1 and 11–15) and PERCS Post-Questionnaire Adapted Version (items/questions 2, 4, 6, 8, and 10). Analysis tests/processes: *F* test for the interaction effect of training and experience followed by multiple comparisons ($p < .05$).

Research Question Three

How do newly licensed pediatric nurses apply communication training content in the clinical pediatric patient care setting?

Hypothesis tested: Nurses participating in the intervention will report their use of one or more habits in the clinical setting positively influencing their communication with parents. Data points: Feedback and responses from participants. Source of data: Post-Intervention Follow-up Survey. Analysis test/process: Content analysis—themes will be identified from the participants' answers to the follow-up survey question using the context of the data, analyst's knowledge, target of the analysis (themes), and inferences made by the analyst (Krippendorff, 1980).

CHAPTER FOUR: FINDINGS

A detailed description of study findings is provided in this chapter. The chapter is structured in three parts. The first part contains information about the composition of the sample, participants' expectations, and participants' prior communication training in preparation for emotion-focused conversations with parents. The second part includes the findings from analysis for the study's three research questions. Finally, the third part of the chapter concludes with a description of additional findings of interest generated in the course of the study.

Sample Composition

Thirty-five nurses participated in the study. Twenty-one participants (60%) were randomized into the intervention group and 14 participants (40%) were randomized into the control group. Participants' pediatric and general nursing experience varied from one month to 23 months, their ages ranged from 21 to 33 years, 29 (82.9%) were female, 26 (74.3%) identified themselves as Caucasian non-Hispanic, and 23 (65.7%) held a Bachelor of Science degree. A summary of participant demographics is provided in Table 5.

Table 5

Demographics of Sample

Characteristic	Intervention (*n* = 21)	Control (*n* = 14)	*n* Total (Percentage)
RN Experience[a] (*SD*)			11.46 (6.68)
1–6	6 (28.5%)	8 (57.1%)	14 (40.0%)
7–12	5 (23.8%)	–	5 (11.3%)
13–18	3 (14.2%)	6 (42.8%)	9 (25.7%)
19–24	7 (33.3%)	–	7 (20.0%)

Table continued

Pediatric RN Experience[a] (*SD*)			9.94 (6.68)
1–6	9 (42.8%)	8 (57.1%)	17 (48.6%)
7–12	4 (19.0%)	–	4 (11.4%)
13–18	4 (19.0%)	6 (42.8%)	10 (28.6%)
19–24	4 (19.0%)	–	4 (11.4%)
Education[b]			
Associate Degree	5 (23.8%)	2 (14.2%)	7 (20.0%)
BS degree 1st degree	14 (66.6%)	9 (64.2%)	23 (65.7%)
BS degree Accelerated	2 (9.5%)	5 (35.7%)	7 (20.0%)
BS degree 2nd degree[c]	2 (9.5%)	1 (7.1%)	3 (8.6%)
Graduate degree: enrolled	1 (4.7%)	–	1 (2.9%)
Age[d] (*SD*)			25.89 (3.36)
21–23	6 (28.5%)	2 (14.2%)	8 (22.9%)
24–26	9 (42.8%)	6 (42.8%)	15 (42.8%)
27–29	3 (14.2%)	2 (14.2%)	5 (14.3%)
30–33	3 (14.2%)	4 (28.5%)	7 (20.0%)
Gender			
Female	18 (85.7%)	11 (78.5%)	29 (82.9%)
Male	3 (14.2%)	3 (21.4%)	6 (17.1%)
Ethnicity			
African American	1 (4.7%)	1 (7.1%)	2 (5.7%)
Asian	–	1 (7.1%)	1 (2.9%)
Caucasian, non-Hispanic	17 (80.9%)	9 (64.2%)	26 (74.3%)
Hispanic	1 (4.7%)	1 (7.1%)	2 (5.7%)
Native American	2 (9.5%)	–	2 (5.7%)
Two or more ethnicities	–	2 (14.2%)	2 (5.7%)

Note. $N = 35$.
[a]*M* in months. [b]Percentages total more than 100%, participants could mark all that applied. [c]2nd degree non-nursing and non-accelerated. [d]*M* in years.

Expectations

Prior to participating in the study, the participants were asked to identify their expectations about the communication-training program. Eight expectations that were previously identified in nursing student-parent communication sessions (Fisher et al., 2012) and an additional "other" category were provided for participants. The three most commonly identified expectations were: (1) Learn how to communicate with parents

better (i.e., tips and suggestions; 100%), (2) Learn more about how nurses can help parents during an emotional time (91.4%), and (3) Recognize what nurses can do to more effectively practice family-centered care (91.4%). The results for all expectations are shown in Table 6 from highest to lowest order according to the number of nurses identifying them as expectations.

Table 6

Participant Expectations

1)	Learn how to communicate with parents better (i.e., tips and suggestions)	100%
2)	Learn more about how nurses can help parents during an emotional time	91.4%
3)	Recognize what nurses can do to more effectively practice family-centered care	91.4%
4)	Practice appropriate responses when communicating with parents	80.0%
5)	Identify ways to incorporate parents more effectively in their child's patient care	80.0%
6)	Increase awareness of parents' expectations during nurse-parent communication	77.1%
7)	List the do's and don'ts of communicating with parents	71.4%
8)	Identify the correct words to use when communicating with parents	71.4%
9)	Other – participant's response: "learn communication techniques to ease anxiety"	2.9%

Previous Communication Training

Participants were asked to describe what kinds of learning opportunities and preparation they had previously that they believed had prepared them for emotion-focused conversations with parents. Over half of the participants (18 or 51.4%) reported that they had communication training they considered preparation for emotion-focused conversations. Twelve of the 21 participants in the intervention group (57.1%) and six of the 14 participants in the control group (42.8%) reported previous training. Information about participants' previous communication training was collected

for descriptive purposes; consequently, analysis was not performed with the data. The different forms of training identified by participants are shown in Table 7.

Table 7

Previous Communication Training

Education/nursing School
- Communication training in nursing school - Nursing school - During school we had clinical time to practice as well as practice with parents during a simulation - Therapeutic communication skills during nursing school - Parent-nurse communication session with parent during nursing school - Nurse-parent communication seminar in nursing school - In both psychiatric and fundamentals of nursing during junior year of undergrad, I received training on therapeutic communication. - Nursing school focus group with parents provided by Mark Fisher - Nursing school/trial and error in the “real world" - OUCON-family centered care modules - OU nursing school parent nurse training - College communication course involving interpersonal communication that I believe can apply; AIDET overview - School clinical with parents of hospitalized children - Had a day in school where we talked a little bit about it and heard from parents of patients
Work Experience, Other Training, or Additional Education
- Communication training at current and former job. substantial coaching during residency program at Cook Children’s. - AIDET - PICU education during orientation (small discussions with other nurses) - I have had a lot of management experience with several trainings on coaching and counseling co-workers, professional comm. and feel that some of that does cross-over.

Formal training during nursing education and new employee orientation were the most commonly mentioned experiences during which they received this form of communication training. Two of the 18 participants (11.1%) reported they had previous communication training that prepared them for emotion-focused conversations with

parents. Both participants identified AIDET as the form of communication training that had prepared them. In addition to communication training to prepare for emotion-focused conversations with parents, participants were also asked if they had received AIDET communication training or Four Habits communication training. The majority, 32 of the 35 participants (91.4%), reported they had received AIDET training. Most nurses participated in AIDET training during their hospital's orientation program. None of the participants reported receiving any form of Four Habits communication training.

Findings

Research Question One

How effective is the Four Habits communication training in preparing newly licensed pediatric nurses for emotion-focused conversations with parents?

Effectiveness was evaluated by examining changes in individual item mean Preparation scores, Communication Skills scores, Relationships scores, Confidence scores, and Anxiety scores on a 1–5 scale. In addition to the five individual items, an overall or Total Preparation score was established by combining all five of the individual items resulting in a summary score that could range from 5–25. Positive changes from lower pretest scores to higher posttest scores were considered improvements. Effectiveness of the training program was also evaluated using five "yes" or "no" questions. These five dichotomous questions addressed whether or not the training program improved participants' Preparation, Communication Skills, Relationships, Confidence, and Anxiety. It was hypothesized that nurses participating in the intervention would show a greater improvement in one or more of the individual scores when compared to the control group. To answer this first question: a pre-post repeated

measures ANOVA with one between-subjects factor (Group: intervention vs. control) was conducted for each of the five dependent variables and the combined total preparation score. Multiple comparisons were performed to further assess differences in means. An independent *t*-test was run to compare the intervention group mean to the control group mean at pretest; another independent *t*-test was run to compare the two group means at posttest; and each groups' change across time was assessed with a paired-samples *t*-test. A conservative Bonferroni approach was taken for controlling the probability of a Type I error for the four *t*-tests. This approach meant that the significance level was set at .0125 for each *t*-test on each dependent variable (Pagano & Gauvreau, 2000; Toothaker, 1991). Participants' responses to the improvement yes or no questions for each of the five individual items are provided. Results for each dependent variable are reported next.

Preparation. Preparation was reported on a scale where higher scores indicate a nurse's better sense of preparation in having emotion-focused conversations with parents. Table 8 shows the ANOVA results for the dependent variable Preparation. The significant interaction indicated that the change across time for the intervention group differed significantly from the change across time for the control group. Nurses' reported mean Preparation in the intervention group post-intervention was significantly higher than the nurses' reported mean Preparation in the control group.

Table 8

Treatment, Time, and Interaction Effects for Preparation

PERCS item	Main effect of Treatment (*intervention/control*)	Main effect of Time (*pre/post*)	Interaction of Treatment and Time (*intervention/control and pre/post*)
Preparation	$F(1,33) = 15.083$ $p < .001$	$F(1,33) = 1.242$ $p < .273$	$F(1,33) = 28.833$ $p < .001$

Figure I1: Preparation Means in Appendix I shows a graph of the Preparation cell means, with the intervention group showing improvement. After the intervention, all 21 participants involved in the intervention responded "yes" to the yes or no question whether or not the training program improved their sense of preparation to engage in emotion-focused conversations with parents.

Pretest scores: For the intervention group, the range of scores was 2 to 4, and the mean reported Preparation pretest level was 2.95. For the control group, the range of scores was 1 to 4, and the mean reported Preparation pretest level was 2.64. Table 9 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Preparation scores at pre-test. Results of the *t*-test analysis for the variable Preparation reflect no significant differences between intervention and control groups at pretest. That is, the two groups were similar prior to treatment sessions and control sessions.

Table 9

PERCS Pre-Questionnaire Adapted Version Preparation

PERCS item: Preparation	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	2.95	0.740	-1.207	27.886	$p = .237$
Control	14	2.64	0.745			

Posttest scores: Table 10 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare the mean Preparation scores at posttest. For the intervention group, the range of scores was 2 to 5, and the mean reported Preparation posttest level was 3.71. For the control group, the range of scores was 1 to 5, and the mean reported Preparation posttest level was 2.14. The *t*-test revealed a significant difference between intervention and control groups. That is, the two groups were different after the intervention sessions and control sessions, with the intervention group's Preparation mean being significantly higher than the control group's mean.

Table 10

PERCS Post-Questionnaire Adapted Version Preparation

PERCS item: Preparation	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	3.71	0.717	-5.272	22.644	$p < .001$
Control	14	2.14	0.949			

Paired-sample *t*-test: Table 11 displays the results of the paired sample *t*-tests for Preparation. These findings revealed a significant improvement in the intervention group's Preparation scores and a trend toward a decline in Preparation scores for the control group, based on the Bonferroni significance level of .0125 per comparison.

Table 11

Paired-Sample t-Test for Preparation

PERCS item: Preparation	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	-0.762	0.700	-4.985	20	$p < .001$
Control	14	0.500	0.650	2.876	13	$p = .013$

Communication skills. Communication Skills were reported on a one-item scale where higher scores indicate a nurses' better Communication Skills in having emotion-focused conversations with parents. Table 12 shows the ANOVA results for the dependent variable Communication Skills. The significant interaction indicated that the change across time for the intervention group differed significantly from the change across time for the control group. Nurses' reported mean Communication Skills in the intervention group post-intervention was significantly higher than the nurses' reported mean Communication Skills in the control group.

Table 12

Treatment, Time, and Interaction Effects for Communication Skills

PERCS item	Main effect of Treatment (*treatment/control*)	Main effect of Time (*pre/post*)	Interaction of Treatment and Time (*intervention/control and pre/post*)
Communication Skills	$F(1,33) = 11.612$ $p = .002$	$F(1,33) = 9.726$ $p = .004$	$F(1,33) = 9.726$ $p = .004$

Figure I2 shows a graph of the Communication Skills cell means, with the intervention group showing improvement. All 21 participants involved in the intervention responded "yes" to the yes or no question whether or not the training program improved their communication skills to engage in emotion-focused conversations with parents.

Pretest scores: For the intervention group, the range of scores was 2 to 5, and the mean reported Communication Skills pretest level was 3.29. For the control group, the range of scores was 2 to 4, and the mean reported Communication Skills pretest level was 2.93. Table 13 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Communication Skills scores at pretest. Communication Skills *t*-test results illustrated non-significant differences between intervention and control groups at pretest. That is, the two groups were similar prior to intervention sessions and control sessions.

Table 13

PERCS Pre-Questionnaire Adapted Version Communication Skills

PERCS item: Communication Skills	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	3.29	.784	-1.505	31.991	$p = .142$
Control	14	2.93	.616			

Posttest scores: Table 14 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare the mean Communication Skills scores at posttest. For the intervention group, the range of scores was 3 to 5, and the mean reported Communication Skills posttest level was 3.95. For the control group, the range of scores was 2 to 4, and the mean reported Communication Skills posttest level was 2.93. The *t*-test revealed a significant difference between intervention and control groups. That is, the two groups were different after the intervention sessions and control sessions with the intervention group's Communication Skills mean being significantly higher than the control group's mean.

Table 14

PERCS Post-Questionnaire Adapted Version Communication Skills

PERCS item: Communication Skills	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	3.95	.590	-4.901	27.155	$p < .001$
Control	14	2.93	.616			

Paired-sample *t*-test: Table 15 displays the results of the paired sample *t*-tests for Communication Skills. These findings revealed a significant improvement in the intervention group's Communication Skills scores based on the Bonferroni significance level of .0125 per comparison. Every participant in the control group reported the same score at pretest and posttest, so the paired *t* could not be computed (standard error = 0).

Table 15

Paired-Sample t-Test for Communication Skills

PERCS item: Communication Skills	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	-0.667	0.796	-3.839	20	$p = .001$
Control	14					

Relationships. Relationships was reported on a scale where higher scores indicate a nurse's better ability in developing and maintaining relationships with parents. Table 16 shows the ANOVA results for the dependent variable Relationships. The significant interaction indicated that the change across time for the intervention group differed significantly from the change across time for the control group. Nurses' reported mean Relationships in the intervention group post-intervention was significantly higher than the nurses' reported mean Relationships in the control group.

Table 16

Treatment, Time, and Interaction Effects for Relationships

PERCS item	Main effect of Treatment (*treatment/control*)	Main effect of Time (*pre/post*)	Interaction of Treatment and Time (*intervention/control and pre/post*)
Relationships	$F(1,33) = 2.441$ $p = .128$	$F(1,33) = 2.084$ $p = .158$	$F(1, 33) = 8.337$ $p = .007$

Figure I3 shows a graph of the Relationships cell means, with the intervention group showing improvement. All 21 participants involved in the intervention responded "yes" to the yes or no question whether or not the training program improved their ability to develop and maintain relationships with parents.

Pretest scores: For the intervention group, the range of scores was 3 to 5, and the mean reported Relationships pretest level was 3.67. For the control group, the range of scores was 2 to 5, and the mean reported Relationships pretest level was 3.64. Table 17 includes the results of a Welch's *t*-tests for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Relationships scores at pre-test. Relationships *t*-test results illustrated non-significant differences between intervention and control groups at pretest. That is, the two groups were similar prior to intervention sessions and control sessions.

Table 17

PERCS Pre-Questionnaire Adapted Version Relationships

PERCS item: Relationships	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	3.67	0.658	-.097	25.556	$p = .923$
Control	14	3.64	0.745			

Posttest scores: Table 18 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare the mean Relationships scores at posttest. For the intervention group, the range of scores was 3 to 5, and the mean reported Relationships posttest level was 4.10. For the control group, the range of scores was 2 to 5, and the mean reported Relationships posttest level was 3.50. The *t*-test revealed a significant difference between intervention and control groups. That is, the two groups were different after the intervention sessions and control sessions with the intervention group's reported Relationships mean being significantly higher than the control group's mean.

Table 18

PERCS Post-Questionnaire Adapted Version Relationships

PERCS item: Relationships	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	4.10	0.436	-2.655	18.762	$p = .016$
Control	14	3.50	0.760			

Paired-sample *t*-test: Table 19 displays the results of the paired sample *t*-tests for Relationships. These findings revealed a significant improvement in the intervention group's Relationships scores and a non-significant change in Relationships scores for the control group, based on the Bonferroni significance level of .0125 per comparison.

Table 19

Paired-Sample t-Test for Relationships

PERCS item: Relationships	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	-0.429	0.598	-3.286	20	$p = .004$
Control	14	0.143	0.535	1.000	13	$p = .336$

Confidence. Confidence was reported on a scale where higher scores indicate a nurses' greater sense of Confidence in having emotion-focused conversations with parents. Table 20 shows the ANOVA results for the dependent variable Confidence. The significant interaction indicated that the change across time for the intervention group differed significantly from the change across time for the control group. Nurses' reported mean Confidence in the intervention group post-intervention was significantly higher than the nurses' reported mean Confidence in the control group.

Table 20

Treatment, Time, and Interaction Effects for Confidence

PERCS item	Main effect of Treatment (*treatment/control*)	Main effect of Time (*pre/post*)	Interaction of Treatment and Time (*intervention/control and pre/post*)
Confidence	$F(1,33) = 4.528$ $p = .041$	$F(1,33) = 5.427$ $p = .026$	$F(1,33) = 36.097$ $p < .001$

Figure I4 shows a graph of the confidence cell means, with the intervention group showing improvement. Twenty participants (95.2%) involved in the intervention responded "yes" to the yes or no question whether or not the training program improved their sense of confidence when engaging in emotion-focused conversations with parents.

Pretest scores: For the intervention group, the range of scores was 2 to 4, and the mean reported confidence pretest level was 2.71. For the control group, the range of scores was 2 to 4, and the mean confidence pretest level was 2.79. Table 21 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean confidence scores at pretest. Confidence *t*-test results illustrated non-significant differences between intervention and control groups at pretest. That is, the two groups were similar prior to intervention sessions and control sessions.

Table 21

PERCS Pre-Questionnaire Adapted Version Confidence

PERCS item: Confidence	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	2.71	0.784	.282	30.148	$p = .780$
Control	14	2.79	0.699			

Posttest scores: Table 22 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare the mean Confidence scores at posttest. For the intervention group, the range of scores was 2 to 4, and the mean Confidence posttest level was 3.52. For the control group, the range of scores was 1 to 4, and the mean reported Confidence posttest level was 2.43. The *t*-test revealed a significant difference between intervention and control groups. That is, the two groups were different after the intervention sessions and control sessions with the intervention group's reported Confidence mean being significantly higher than the control group's mean.

Table 22

PERCS Post-Questionnaire Adapted Version Confidence

PERCS item: Confidence	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	3.52	0.602	-3.872	20.12	$p = .001$
Control	14	2.43	0.938		9	

Paired-sample *t*-test: Table 23 displays the results of the paired sample *t*-tests for Confidence. These findings revealed a significant improvement in the intervention group's Confidence scores and a trend toward a decline in Confidence scores for the control group, based on the Bonferroni significance level of .0125 per comparison.

Table 23

Paired-Sample t-Test for Confidence

PERCS item: Confidence	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	-0.810	0.602	-6.167	20	$p < .001$
Control	14	0.357	0.497	2.687	13	$p = .019$

Anxiety. Anxiety was originally reported on a scale where lower scores reflected a nurse's lower sense of anxiety about having emotion-focused conversations with parents. However, participants' original Anxiety scores were reverse scored prior to analysis which resulted in higher scores indicating a nurse's lower sense of anxiety about having emotion-focused conversations with parents. Table 24 shows the ANOVA results for the dependent variable Anxiety. No significant differences in the change across time were detected for both the intervention group and control group. Nurses' reported mean Anxiety in the intervention group was not significantly different than the nurses' reported mean Anxiety in the control group.

Table 24

Treatment, Time, and Interaction Effects for Anxiety

PERCS item	Main effect of Treatment (*intervention/control*)	Main effect of Time (*pre/post*)	Interaction of Treatment and Time (*intervention/control and pre/post*)
Anxiety	$F(1,33) = 0.254$ $p = .617$	$F(1,33) = 2.200$ $p = .147$	$F(1,33) = 2.200$ $p = .147$

Figure I5 shows a graph of the Anxiety cell means, with minimal non-significant differences between treatment group means and control group means. Eighteen participants (85.7%) involved in the intervention responded "yes" to the yes or no question about whether or not the training program reduced their sense of anxiety when engaging in emotion-focused conversations with parents.

Pretest scores: For the intervention group, the range of scores was 2 to 5, and the mean reported Anxiety pretest level was 3.48. For the control group, the range of scores was 2 to 5, and the mean Anxiety pretest level was 3.50. Table 25 includes the results of a Welch's *t*-tests for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Anxiety scores at pretest. Anxiety *t*-test results illustrated non-significant differences between intervention and control groups. That is, the two groups were similar prior to intervention sessions and control sessions.

Table 25

PERCS Pre-Questionnaire Adapted Version Anxiety

PERCS item: Anxiety	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	3.48	0.814	.088	29.336	$p = .930$
Control	14	3.50	0.760			

Posttest scores: Table 26 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare the mean Anxiety scores at posttest. For the intervention group, the range of scores was 3 to 5, and the mean Anxiety posttest level was 3.76. For the control group, the range of scores was 2 to 5, and the mean reported anxiety posttest level was 3.50. Although the trend was in the expected direction, the size of the difference was statistically negligible. These findings revealed no significant differences between intervention and control groups. That is, the two groups' change over time was not significantly different from each other after the intervention sessions and control sessions.

Table 26

PERCS Post-Questionnaire Adapted Version Anxiety

PERCS item: Anxiety	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	3.76	0.625	-1.071	24.179	$p = .295$
Control	14	3.50	0.760			

Paired-sample *t*-test: Table 27 displays the results of the paired sample *t*-tests for Anxiety. These findings revealed a non-significant change in the intervention group's Anxiety scores and no change in the control group's Anxiety scores, based on the Bonferroni significance level of .0125 per comparison.

Table 27

Paired-Sample t-Test for Anxiety

PERCS item: Anxiety	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	-.286	.644	-2.034	20	$p = .055$
Control	14	.000	.392	.000	13	$p = 1.00$

Total preparation. Total Preparation was reported on a scale where higher scores indicate a nurse's greater sense of overall preparation for emotion-focused conversations with parents. Table 28 shows the ANOVA results for the dependent variable Total Preparation. The significant interaction indicated that the change across time for the intervention group differed significantly from the change across time for the control group. Nurses' reported mean Total Preparation in the intervention group was significantly higher than the nurses' reported Total Preparation in the control group.

Table 28

Treatment, Time, and Interaction Effects for Total Preparation

All PERCS items	Main effect of Treatment (*treatment/control*)	Main effect of Time (*pre/post*)	Interaction of Treatment and Time (*intervention/control and pre/post*)
Total Preparation	$F(1,33) = 8.251$ $p = .007$	$F(1,33) = 11.617$, $p = .002$	$F(1,33) = 47.610$ $p < .001$

Figure I6 shows a graph of the Total Preparation cell means, with the intervention group showing improvement.

Pretest scores: For the intervention group, the range of scores was 12 to 23, and the mean reported Total Preparation pretest level was 16.10. For the control group, the range of scores was 11 to 20, and the mean Total Preparation level was 15.50. Table 29

includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Total Preparation scores at pretest. Total Preparation *t*-test results illustrated non-significant differences between intervention and control groups. That is, the two groups were similar prior to intervention sessions and control sessions.

Table 29

PERCS Pre-Questionnaire Adapted Version Total Preparation

All PERCS items: Total Preparation	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	16.10	2.473	-.633	31.688	$p = .531$
Control	14	15.50	3.064			

Posttest scores: Table 30 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare the mean Total Preparation scores at posttest. For the intervention group, the range of scores was 14 to 24, and the mean Total Preparation posttest level was 19.05. For the control group, the range of scores was 10 to 20, and the mean reported Total Preparation posttest level was 14.50. These findings revealed a significant difference between intervention and control groups. That is, the two groups were different after the treatment sessions and control sessions with the intervention group's reported Total Preparation mean being significantly higher than the control group's mean.

Table 30

PERCS Post-Questionnaire Adapted Version Total Preparation

All PERCS items: Total Preparation	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	19.05	2.334	-4.839	23.430	$p < .001$
Control	14	14.50	2.955			

Paired-sample *t*-test: Table 31 displays the results of the paired sample *t*-tests for Total Preparation. These findings revealed a significant improvement in the intervention group's Total Preparation scores and a trend toward a decline in Total Preparation scores for the control group, based on the Bonferroni significance level of .0125 per comparison.

Table 31

Paired-Sample t-Test for Total Preparation

All PERCS items: Total Preparation	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Intervention	21	-2.952	1.857	-7.287	20	$p < .001$
Control	14	1.000	1.301	2.876	13	$p = .013$

Table 32 displays a summary of the ANOVA results for the dependent variables Preparation, Communication Skills, Relationships, Confidence, Anxiety, and Total Preparation. The significant interactions in five of the six dependent variables (i.e., exception Anxiety) indicated that the change across time for the intervention group differed significantly from the change across time for the control group.

Table 32

Summary ANOVA Results for Treatment, Time, and Interaction Effects

PERCS item	Interaction of Treatment and Time (*intervention/control and pre/post*)
Preparation	$F(1,33) = 28.833$, $p < .001$
Communication Skills	$F(1,33) = 9.726$, $p = .004$
Relationships	$F(1, 33) = 8.337$, $p = .007$
Confidence	$F(1,33) = 36.097$, $p < .001$
Anxiety	$F(1,33) = 2.200$, $p = .147$
All PERCS items Total Preparation	$F(1,33) = 47.610$, $p < .001$

Research Question Two

Is there an interaction between training and the amount of experience in nurses' preparation for emotion-focused conversations?

This question was informed by Benner's novice to expert theory (Benner, 1984; Benner et al., 2009), which served as the basis for the hypothesis about the interaction between training and RN experience. It was hypothesized that nurses with fewer months of experience participating in the intervention would show greater improvement in their individual and overall preparedness scores when compared to nurses with greater months of experience in the intervention group. To answer this second question, experience was dichotomized as "less than 12 months of RN experience" (< 12 m) and "12 months or more of RN experience" (≥ 12 m). A two-between (experience level and treatment), one-within (pre and post) repeated measures analysis of variance (ANOVA) was calculated for each of the five dependent variables and the combined Total Preparation score. If the three-way interaction was significant, it could indicate that the effect of intervention across time depended on nurse experience. Multiple comparisons were

performed to further assess differences in means. An independent *t*-test was run to compare the intervention group mean to the control group mean at pretest; another independent *t*-test was run to compare the two group means at posttest; and each groups' change across time was assessed with a paired-samples *t*-test. Again, a conservative Bonferroni approach was taken for controlling the probability of a Type I error for the four *t*-tests. This approach meant that the significance level was set at .0125 for each *t*-test on each dependent variable (Pagano & Gauvreau, 2000; Toothaker, 1991). Results for each dependent variable are reported next.

Preparation. Table 33 includes the ANOVA results for the dependent variable Preparation. A difference in the changes from pretest to posttest scores for both experience levels was not detected. Change across time for nurses with less than 12 months experience did not differ significantly from the change across time for nurses with 12 or more months of experience. The previously observed two-way interaction between treatment and time was not modified by the inclusion of RN experience as a factor.

Table 33

Months of RN Experience and Interaction Effects for Preparation

PERCS item	Main effect of Months of RN Experience (*<12 m/≥ 12 m*)	Interaction: Time and Months of RN Experience (*pre/post and <12 m/≥ 12 m*)	Interaction: Time, Treatment, and Months of RN experience (*pre/post, intervention/control, and <12 m/≥ 12 m*)
Preparation	$F(1, 31) = 0.863$ $p = .360$	$F(1,31) = 0.022$, $p = .882$	$F(1,31) = 0.022$, $p = .882$

Figure J1 show graphs of Preparation cell means of the less experienced nurses and more experienced nurses exhibiting the non-significant three-way interaction. Less experienced

nurses involved in the intervention improved at a similar level as more experienced nurses. The improvement in Preparation for nurses with less than 12 months experience did not differ significantly from the improvement in Preparation for nurses with 12 or more months of experience.

Pretest scores: For the nurses in the intervention group with less than 12 months experience, the range of scores was 2 to 4, and the mean reported Preparation pretest level was 2.91. For the nurses in the intervention group with 12 months experience or greater, the range of scores was 2 to 4, and the mean reported Preparation pretest level was 3.00. Table 34 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Preparation scores at pretest for nurses involved in the intervention. Preparation *t*-test results illustrated a non-significant difference between nurses with different experience levels involved in the intervention at pretest. That is, the two groups were similar prior to treatment sessions.

Table 34

PERCS Pre-Questionnaire Adapted Version Preparation—Intervention Group

PERCS item: Preparation	Experience	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Pre-PERCS	< 12 m	11	2.91	0.701	-0.273	17.874	$p = .788$
	≥ 12 m	10	3.00	0.816			

Posttest scores: For the nurses in the intervention group with less than 12 months experience, the range of scores was 3 to 5, and the mean reported Preparation posttest level was 3.64. For the nurses in the intervention group with 12 months experience or greater, the range of scores was 2 to 4, and the mean reported Preparation posttest level was 3.80. Table 35 includes the results of a Welch's *t*-test for "equal variances not

assumed" (Glass & Hopkins, 1996) used to compare mean Preparation scores at posttest for nurses involved in the intervention. Preparation *t*-test results illustrated a non-significant difference between nurses with different experience levels involved in the intervention at posttest. That is, the two groups were similar following intervention sessions.

Table 35

PERCS Post-Questionnaire Adapted Version Preparation– Intervention Group

PERCS item: Preparation	Experience	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	11	3.64	.924	-.530	14.270	$p = .605$
	≥ 12 m	10	3.80	.422			

Paired sample *t*-test: Tables 36 and 37 display the results of the paired sample *t*-tests for Preparation, with the nurses stratified by experience level. These findings revealed an improvement in the intervention group's preparation scores for the nurses at both levels of experience, a trend toward decline in the control group's preparation scores for less experienced nurses, and no change for control-group nurses with more. These findings were based on the Bonferroni significance level of .0125 per comparison.

Table 36

Paired-Sample t-Test for Preparation—Intervention Group

PERCS item: Preparation	Experience	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	11	-0.727	0.786	-3.068	10	$p = .012$
	≥ 12 m	10	-0.800	0.632	-4.000	9	$p = .003$

Table 37

Paired-Sample t-Test for Preparation—Control Group

PERCS item: Preparation	Experience	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	8	0.500	0.535	2.646	7	$p = .033$
	≥ 12 m	6	0.500	0.837	1.464	5	$p = .203$

Communication skills. Table 38 includes the ANOVA results for the dependent variable Communication Skills. A difference in the changes from pretest to posttest scores for experience level groups was not detected. Change across time for nurses with less than 12 months experience did not differ significantly from the change across time for nurses with 12 or more months of experience. The previously observed two-way interaction between treatment and time was not modified by the inclusion of RN experience as a factor.

Table 38

Months of RN Experience and Interaction Effects for Communication Skills

PERCS item	Main effect of Months of RN Experience (*<12 m/≥ 12 m*)	Interaction: Time and Months of RN Experience (*pre/post and <12 m/≥ 12 m*)	Interaction: Time, Treatment, and Months of RN experience (*pre/post, intervention/control, and <12 m/≥ 12 m*)
Communication Skills	$F(1, 31) = 0.193$ $p = .664$	$F(1,31) = 0.021$, $p = .887$	$F(1,31) = 0.021$, $p = .887$

Figure J2 shows graphs of Communication Skills cell means of the less experienced nurses and more experienced nurses exhibiting the non-significant three-way interaction. Less experienced nurses involved in the intervention improved their Communication Skills at a similar level as more experienced nurses. The improvement in Communication

Skills for nurses with less than 12 months experience did not differ significantly from the improvement in Communication Skills for nurses with 12 or more months of experience.

Pretest scores: For the nurses in the intervention group with less than 12 months experience, the range in scores was 2 to 5, and the mean reported Communication Skills pretest level was 3.27. For the nurses in the intervention group with 12 months experience or greater, the range in scores was 2 to 4, and the mean reported Communication Skills pretest level was 3.30. Table 39 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Communication Skills scores at pretest for nurses involved in the intervention. Communication skills *t*-test results illustrated a non-significant difference between nurses with different experience levels involved in the intervention at pretest. That is, the two groups were similar prior to intervention sessions.

Table 39

PERCS Pre-Questionnaire Adapted Version Communication Skills —Intervention Group

PERCS item: Communication Skills	Experience	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Pre-PERCS	< 12 m	11	3.27	0.905	-0.079	18.352	$p = .938$
	≥ 12 m	10	3.30	0.675			

Posttest scores: For the nurses in the intervention group with less than 12 months experience, the range of scores was 3 to 5, and the mean reported Communication Skills posttest level was 3.91. For the nurses in the intervention group with 12 months experience or greater, the range in scores was 3 to 5, and the mean reported Communication Skills posttest level was 4.00. Table 40 includes the results of a Welch's

t-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Communication Skills scores at posttest for nurses involved in the intervention. Communication Skills *t*-test results illustrated no significant differences between nurses with different experience levels involved in the intervention at posttest. That is, the two groups were similar following treatment sessions.

Table 40

PERCS Post-Questionnaire Adapted Version Communication Skills —Intervention Group

PERCS item: Communication Skills	Experience	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	11	3.91	0.701	-0.352	17.592	*p* = .729
	≥ 12 m	10	4.00	0.471			

Paired-sample *t*-test: Tables 41 displays the results of the paired sample *t*-tests for Communication Skills. These findings revealed a trend toward improvement in the intervention group's Communication Skills scores for the nurses with less experience and a significant improvement in the more experienced nurses' Communication Skills. Every participant in the control group reported the same score at pretest and posttest, so the paired *t*-tests could not be computed (standard errors = 0). These findings were based on the Bonferroni significance level of .0125 per comparison.

Table 41

Paired Sample t-Test for Communication Skills—Intervention Group

PERCS item: Communication Skills	Experience	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	11	- 0.636	0.924	-2.283	10	*p* = .046
	≥ 12 m	10	-0.700	0.675	-3.280	9	*p* = .010

Relationships. Table 42 includes the ANOVA results for the dependent variable Relationships. A difference in the changes from pretest to posttest scores for both experience levels was not detected. Change across time for nurses with less than 12 months experience did not differ significantly from the change across time for nurses with 12 or more months of experience. The previously observed two-way interaction between treatment and time was not modified by the inclusion of RN experience as a factor.

Table 42

Months of RN Experience and Interaction Effects for Relationships

PERCS item	Main effect of Months of RN Experience (*<12 m/≥ 12 m*)	Interaction: Time and Months of RN Experience (*pre/post and <12 m/≥ 12 m*)	Interaction: Time, Treatment, and Months of RN experience (*pre/post, intervention/control, and <12 m/≥ 12 m*)
Relationships	$F(1, 31) = 1.548$ $p = .223$	$F(1,31) = 0.231$, $p = .634$	$F(1,31) = 0.561$, $p = .460$

Figure J3 shows graphs of Relationships cell means of the less experienced nurses and more experienced nurses exhibiting the non-significant three-way interaction. Less experienced nurses involved in the intervention improved their Relationships at a similar level as more experienced nurses. The improvement in Relationships for nurses with less than 12 months experience did not differ significantly from the improvement in Relationships for nurses with 12 or more months of experience.

Pretest scores: For the nurses in the intervention group with less than 12 months experience, the range in scores was 3 to 5, and the mean Relationships pretest level was 3.64. For the nurses in the intervention group with 12 months experience or greater, the range in scores was 3 to 5, and the mean reported Relationships pretest level was 3.70.

Table 43 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Relationships scores at pretest for nurses involved in the intervention. Relationships *t*-test results illustrated a non-significant difference between nurses with different experience levels involved in the intervention at pretest. That is, the two groups were similar prior to intervention sessions.

Table 43

PERCS Pre-Questionnaire Adapted Version Establish Relationships – Intervention Group

PERCS item: Relationships	Experience	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Pre-PERCS	< 12 m	11	3.64	0.674	-0.216	18.806	$p = .831$
	≥ 12 m	10	3.70	0.675			

Posttest scores: For the nurses in the intervention group with less than 12 months experience, the range of scores was 3 to 5, and the mean reported Relationships posttest level was 4.09. For the nurses in the intervention group with 12 months experience or greater, the range in scores was 4 to 5, and the mean reported Relationships posttest level was 4.10. Table 44 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Relationships scores at posttest for nurses involved in the intervention. Relationships *t*-test results illustrated a non-significant difference between nurses with different experience levels of experience involved in the intervention at posttest. That is, the two groups were similar following intervention sessions.

Table 44

PERCS Post-Questionnaire Adapted Version Relationships—Intervention Group

PERCS item: Relationships	Experience	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	11	4.09	0.924	-0.048	16.389	$p = .963$
	≥ 12 m	10	4.10	0.422			

Paired-sample *t*-test: Tables 45 and 46 display the results of the paired sample *t*-tests for Relationships. These findings revealed a trend toward improvement in the intervention group's Relationships scores for the nurses with less experience and no significant change for more experienced nurses. No change was observed in the control group's Relationships scores for nurses with either level of experience. These findings were based on the Bonferroni significance level of .0125 per comparison.

Table 45

Paired Sample t-Test for Relationships—Intervention Group

PERCS item: Relationships	Experience	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	11	-0.455	0.522	-2.887	10	$p = .016$
	≥ 12 m	10	-0.400	0.699	-1.809	9	$p = .104$

Table 46

Paired Sample t-Test for Relationships—Control Group

PERCS item: Relationships	Experience	*n*	*M Difference*	*SD*	*t*	df	Sig. (2-tailed)
Post-PERCS	< 12 m	8	0.250	0.463	1.528	7	$p = .170$
	≥ 12 m	6	0.000	0.632	0.000	5	$p = 1.000$

Confidence. Table 47 includes the ANOVA results for the dependent variable Confidence. A difference in the changes from pretest to posttest scores for both experience levels was not detected. Change across time for nurses with less than 12 months experience did not differ significantly from the change across time for nurses with 12 or more months of experience. The previously observed two-way interaction between treatment and time was not modified by the inclusion of RN experience as a factor.

Table 47

Months of RN Experience and Interaction Effects for Confidence

PERCS item	Main effect of Months of RN Experience (*<12 m/≥ 12 m*)	Interaction: Time and Months of RN Experience (*pre/post and <12 m/≥ 12 m*)	Interaction: Time, Treatment, and Months of RN experience (*pre/post, intervention/control, and <12 m/≥ 12 m*)
Confidence	$F(1, 31) = 1.765$ $p = .194$	$F(1,31) = 0.176$, $p = .678$	$F(1,31) = 0.395$, $p = .534$

Figure J4 shows graphs of Confidence cell means of the less experienced nurses and more experienced nurses exhibiting the non-significant three-way interaction. Less experienced nurses involved in the intervention improved their Confidence at a similar level as more experienced nurses. The improvement in Confidence for nurses with less than 12 months experience did not differ significantly from the improvement in Confidence for nurses with 12 or more months of experience.

Pretest scores: For the nurses in the intervention group with less than 12 months experience, the range of scores was 2 to 4, and the mean reported Confidence pretest level was 2.55. For the nurses in the intervention group with 12 months experience or greater, the range of scores was 2 to 4, and the mean reported Confidence pretest level

was 2.90. Table 48 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Confidence scores at pretest for nurses involved in the intervention. Confidence *t*-test results illustrated a non-significant difference between nurses with different experience levels involved in the intervention. That is, the two groups were similar prior to intervention sessions.

Table 48

PERCS Pre-Questionnaire Adapted Version Confidence—Intervention Group

PERCS item: Confidence	Experience	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Pre-PERCS	< 12 m	11	2.55	0.820	-1.043	18.999	$p = .310$
	≥ 12 m	10	2.90	0.738			

Posttest scores: For the nurses in the intervention group with less than 12 months experience, the range of scores was 2 to 4, and the mean reported Confidence posttest level was 3.45. For the nurses in the intervention group with 12 months experience or greater, the range of scores was 3 to 5, and the mean reported Confidence posttest level was 3.60. Table 49 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Confidence scores at posttest for nurses involved in the intervention. Confidence *t*-test results illustrated a non-significant difference between nurses with different experience levels involved in the intervention. That is, the two groups were similar following intervention sessions.

Table 49

PERCS Post-Questionnaire Adapted Version Confidence—Intervention Group

PERCS item: Confidence	Experience	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	11	3.45	0.688	-0.055	18.392	$p = .588$
	≥ 12 m	10	3.60	0.516			

Paired-sample *t*-test: Tables 50 and 51 display the results of the paired sample *t*-tests for Confidence. These findings revealed an improvement in the intervention group's Confidence scores for the nurses at both levels of experience and no significant change in the control group's Confidence scores for nurses at either levels of experience. These findings were based on the Bonferroni significance level of .0125 per comparison.

Table 50

Paired Sample t-Test for Confidence—Intervention Group

PERCS item: Confidence	Experience	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	11	-0.909	0.701	-4.303	10	$p = .002$
	≥ 12 m	10	-0.700	0.483	-4.583	9	$p = .001$

Table 51

Paired Sample t-Test for Confidence—Control Group

PERCS item: Confidence	Experience	*n*	*M Difference*	SD	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	8	0.375	0.518	2.049	7	$p = .080$
	≥ 12 m	6	0.333	0.516	1.581	5	$p = .175$

Anxiety. Table 52 includes the ANOVA results for the dependent variable Anxiety. The main effect of experience was not significant. Change across time for

nurses with less than 12 months experience differed significantly from the change across time for nurses with 12 or more months of experience. Additionally, an interaction occurred between time, treatment, and experience that was significant. The previously observed two-way interaction between treatment and time was modified by the inclusion of RN experience as a factor.

Table 52

Months of RN Experience and Interaction Effects for Anxiety

PERCS item	Main effect of Months of RN Experience (*<12 m/≥ 12 m*)	Interaction: Time and Months of RN Experience (*pre/post and <12 m/≥ 12 m*)	Interaction: Time, Treatment, and Months of RN experience (*pre/post, intervention/control, and <12 m/≥ 12 m*)
Anxiety	$F(1, 31) = 0.449$ $p = .508$	$F(1,31) = 5.733$, $p = .023$	$F(1,31) = 5.733$, $p = .023$

Figure J5 shows graphs of Anxiety cell means of the less experienced nurses and more experienced nurses exhibiting the significant three-way interaction. Less experienced nurses involved in the intervention did not show an improvement in their Anxiety. Instead, their Anxiety level showed a slight decline (i.e., increase in self-reported anxiety). More experienced nurses involved in the intervention improved their Anxiety scores at a different level than nurses with less experience. There were no improvements in Anxiety for nurses with less than 12 months experience; however, there were significant improvements in Anxiety for nurses with more than 12 or months experience.

Pretest scores: For the nurses in the intervention group with less than 12 months experience, the range of scores was 3 to 5, and the mean reported Anxiety pretest level was 3.82. For the nurses in the intervention group with 12 months experience or greater,

the range of scores was 2 to 4, and the mean reported Anxiety pretest level was 3.10. Table 53 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Anxiety scores at pretest for nurses involved in the intervention. Anxiety *t*-test results illustrated a significant difference between nurses with different experience levels involved in the intervention. The two groups were not similar prior to intervention sessions. Nurses with less experience mean Anxiety scores were significantly higher prior to the intervention.

Table 53

PERCS Pre-Questionnaire Adapted Version Anxiety—Intervention Group

PERCS item: Anxiety	Experience	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Pre-PERCS	< 12 m	11	3.82	0.751	2.209	18.870	$p = .040$
	≥ 12 m	10	3.10	0.738			

Posttest scores: For the nurses in the intervention group with less than 12 months experience, the range of scores was 3 to 5, and the mean reported Anxiety posttest level was 3.73. For the nurses in the intervention group with 12 months experience or greater, the range of scores was 3 to 5, and the mean reported Anxiety posttest level was 3.80. Table 54 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Anxiety scores at posttest for nurses involved in the intervention. Anxiety *t*-test results illustrated a non-significant difference between nurses with different experience levels involved in the treatment. That is, the two groups were similar following intervention sessions.

Table 54

PERCS Post-Questionnaire Adapted Version Anxiety—Intervention Group

PERCS item: Anxiety	Experience	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	11	3.73	0.751	-0.260	18.885	$p = .797$
	≥ 12 m	10	3.80	0.632			

Paired-sample *t*-test: Tables 55 and 56 display the results of the paired sample *t*-tests for Anxiety. More experienced nursed in the intervention group reported significantly lower Anxiety scores at posttest, compared with pretest; no other comparisons were significant at the Bonferroni significance level of .0125 per comparison. Every nurse in the control group with less experience reported the same score at pretest and posttest, so the paired *t* could not be computed (standard error = 0).

Table 55

Paired Sample t-Test for Anxiety—Intervention Group

PERCS item: Anxiety	Experience	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	11	0.091	0.539	-0.271	10	$p = .588$
	≥ 12 m	10	-0.700	0.483	-4.583	9	$p = .001$

Table 56

Paired Sample t-Test for Anxiety—Control Group

PERCS item: Anxiety	Experience	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	8	–	–	–	–	–
	≥ 12 m	6	.000	.632	.000	5	$p = 1.000$

Total preparation. Table 57 includes the ANOVA results for the dependent variable Total Preparation. A difference in the changes from pretest to posttest scores for both experience levels was not detected. Change across time for nurses with less than 12 months experience did not differ significantly from the change across time for nurses with 12 or more months of experience. The previously observed two-way interaction between treatment and time was not modified by the inclusion of RN experience as a factor.

Table 57

Months of RN Experience and Interaction Effects for Total Preparation

All PERCS items	Main effect of Months of RN Experience (*<12 m/≥ 12 m*)	Interaction: Time and Months of RN Experience (*pre/post and <12 m/≥ 12 m*)	Interaction: Time, Treatment, and Months of RN experience (*pre/post, intervention/control, and <12 m/≥ 12 m*)
Total Preparation	$F(1, 31) = 0.636$ $p = .431$	$F(1,31) = 0.664$, $p = .422$	$F(1,31) = 0.101$, $p = .753$

Figure J6 shows graphs of Total Preparation cell means of the less experienced nurses and more experienced nurses exhibiting the non-significant three-way interaction. Less experienced nurses involved in the intervention improved their Total Preparation at a similar level as more experienced nurses. The improvement in Total Preparation for nurses with less than 12 months experience did not differ significantly from the improvement in Total Preparation for nurses with 12 or more months of experience.

Pretest scores: For the nurses in the intervention group with less than 12 months experience, the range in scores was 12 to 23, and the mean reported Total Preparation pretest level was 16.18. For the nurses in the intervention group with 12 months

experience or greater, the range in scores was 12 to 20, and the mean reported Total Preparation pretest level was 16.00. Table 58 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Total Preparation scores at pretest for nurses involved in the intervention. Total Preparation *t*-test results illustrated a non-significant difference between nurses with different experience levels involved in the intervention. That is, the two groups were similar prior to intervention sessions.

Table 58

PERCS Pre-Questionnaire Adapted Version Total Preparation—Intervention Group

All PERCS items: Total Preparation	Experience	*n*	Mean	*SD*	*t*	*df*	Sig. (2-tailed)
Pre-PERCS	< 12 m	11	16.18	3.401	0.13	18.869	$p = .895$
	≥ 12 m	10	16.00	2.828			

Posttest scores: For the nurses in the intervention group with less than 12 months experience, the range of scores was 14 to 22, and the mean reported Total Preparation posttest level was 18.82. For the nurses in the intervention group with 12 months experience or greater, the range of scores was 16 to 21, and the mean reported Total Preparation posttest level was 19.30. Table 59 includes the results of a Welch's *t*-test for "equal variances not assumed" (Glass & Hopkins, 1996) used to compare mean Total Preparation scores at posttest for nurses involved in the intervention. Total Preparation *t*-test results illustrated a non-significant difference between nurses with different experience levels involved in the intervention. That is, the two groups were similar following intervention sessions.

Table 59

PERCS Post-Questionnaire Adapted Version Total Preparation—Intervention Group

All PERCS items: Total Preparation	Experience	*n*	*M*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	11	18.82	2.822	-0.473	16.977	$p = .642$
	≥ 12 m	10	19.30	1.767			

Paired-sample *t*-test: Tables 60 and 61 display the results of the paired sample *t*-tests for Total Preparation. These findings revealed an improvement in the intervention group's Total Preparation scores for the nurses at both levels of experience, a trend toward decline in the control group's Total Preparation scores for nurses with less experience, and no significant change for the more experienced nurse in the control group. These findings were based on the Bonferroni significance level of .0125 per comparison.

Table 60

Paired Sample t-Test for Total Preparation— Intervention Group

All PERCS items: Total Preparation	Experience	*n*	Mean Difference	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	11	-2.636	2.014	-4.342	10	$p = .001$
	≥ 12 m	10	-3.300	1.703	-6.128	9	$p < .001$

Table 61

Paired Sample t-Test for Total Preparation— Control Group

All PERCS items: Total Preparation	Experience	*n*	*M Difference*	*SD*	*t*	*df*	Sig. (2-tailed)
Post-PERCS	< 12 m	8	1.125	0.991	3.211	7	$p = .015$
	≥ 12 m	6	0.833	1.722	1.185	5	$p = .289$

Table 62 displays a summary of the ANOVA results based on nurses' level of experience and the dependent variables Preparation, Communication Skills, Relationships, Confidence, Anxiety, and Total Preparation. The interaction between experience and Anxiety indicated that the change in Anxiety across time for more experienced nurses differed significantly from the change in Anxiety across time for less experienced nurses.

Table 62

Summary ANOVA Results for Time, Treatment, and Months of RN Experience

PERCS item	Interaction: Time, Treatment, and Months of RN experience (*pre/post, intervention/control, and <12 m/≥ 12 m*)
Preparation	$F(1,31) = 0.022$, $p = .882$
Communication Skills	$F(1,31) = 0.021$, $p = .887$
Relationships	$F(1,31) = 0.561$, $p = .460$
Confidence	$F(1,31) = 0.395$, $p = .534$
Anxiety	$F(1,31) = 5.733$, $p = .023$
All PERCS items Total Preparation	$F(1,31) = 0.101$, $p = .753$

Research Question Three

How do newly licensed pediatric nurses apply communication training content in the clinical pediatric patient care setting?

Application of training content was evaluated by examination of participants' responses to a follow-up question. Participants were asked to respond to the following question: "Please think of a time in the past two weeks where you used one or more of the Four Habits that you learned about in the communication training session. The experience may have been positive or negative. Please write down the story of that time."

Responses were then sent from the participant to the research coordinator, de-identified, and provided for review and analysis. It was hypothesized that nurses participating in the intervention would report their use of one or more habits in the clinical setting positively influencing their communication with parents. Responses were examined using content analysis with considerations for the data's context, reviewer's knowledge, goal of the review, inferences, and validity (Krippendorff, 1980). Answers obtained from treatment group participants were included and analyzed when participants referenced one or more of the Four Habits (Habit 1: Invest in the Beginning, Habit 2: Elicit the Parent's Perspective, Habit 3: Demonstrate Empathy, and Habit 4: Invest in the End). It was assumed that participants' responses addressed care they provided after participating in the communication training program.

Reponses from the email survey produced data from 28 of the 35 participants (80.0%). Stories were received from 18 of the 21 intervention group participants (85.7%) and information was received from 10 of the 14 control group participants (71.4%). Answers from the control group were not included in the content analysis because their responses did not address application of communication training content and thus were reflective of a different context. Participants in the control group provided responses such as: "I watched the video," "I was in the control group," and "I did not participate in the study group." Responses from participants in the intervention group fell into three categories, general reference to the Four Habits, incomplete, or specific reference to the Four Habits. Responses from 7 of the 18 intervention group participants (38.8%) either generally addressed the Four Habits (i.e., a story was not provided) or were incomplete

(i.e., difficult to discern each of the Four Habits in participant's response) as shown in Table 63.

Table 63

Intervention Group Responses

General or Incomplete
- There is no particular story I can tell you about but I use at least on (one) of the four habits every time I work. - Talking to parents constantly. I cannot think of a particular moment at this time - I wish I had a story where I have utilized these habits, but I have not consciously used this model to communicate. I need to study and practice it more, before I can use it effectively. - I haven't had an experience that I needed to use the Four Habits in. - A mother and father were upset that their child was not receiving pain medication. After using the techniques of the four habits the parents revealed that they were more upset because they were stressed from not knowing what was wrong and because they were exhausted. - N/A

Note. One incomplete response was determined to be incomplete because it contained the punctuation of a period, i.e., "."

Coding of the content was completed using the Nurse Participant Four Habits Manual (Appendix C: Nurse/Participant Training Manual) and the Four Habits Training and Evaluation Checklist contained in the participant training manual. The manual and checklist were both used with the nurses involved in the treatment sessions. Eleven of the 18 participants (61.1%) in the treatment group provided responses that specifically referenced one or more of the Four Habits. Frequency of participant's use of the Four Habits and an example of each of the Four Habits by several different nurses are provided in Table 64.

Table 64

Application of the Four Habits in Clinical Practice

Habit	Frequency of Use	Example
Habit 1: Invest in the Beginning	6/11 54.5%	Investing in the beginning by being friendly and introducing myself has helped with all my parent interactions.
Habit 2: Elicit the Parent's Perspective	7/11 63.6%	I've tried my hardest to ensure the family and I are on the same page. Caught myself sitting down and listening to family concerns has helped open up the parents.
Habit 3: Demonstrate Empathy	8/11 72.7%	I had a patient that needed blood and the father of the patient was pacing and kept sighing. It was very tense in the room, so I said to him that he seemed worried and asked him what he was feeling. He said nobody asked him how he felt about it or if he had questions. He also said none of the nurses explained what they were doing to his child and he wanted to know. He opened up to me and I was able to listen
Habit 4: Invest in the End	9/11 or 81.8%	I also let her know that I would pass along in report that the nurse should only give out information to other people if the parents have agreed to it & if they have the pin number. I asked her if she had any concerns or suggestions on how to improve the situation. She felt these solutions would improve the privacy of the patient & family, and she did not have any thing else to contribute for ideas.

One of the participants involved in the intervention identified all Four Habits in their response and is provided in Table 65.

Table 65

Participant's Story Addressing All Four Habits

Habit	Example
Habit 1: Invest in the Beginning	I introduced myself, found out names and used names, clearly explained our plan for the day.
Habit 2: Elicit Parent's Perspective	I've had pts where I used habit 2 and 3 where parents were upset about an aspect of their care, one I remember was upset about anesthesia's manner in speaking with them, she felt some information that was given in front of child pt, should have been explained else where so as not to scare the pt.
Habit 3: Demonstrate Empathy	I took the time to listen and asked mother what she felt they should have done and what we could do better next time, I remember using words like "it sounds that you your concerns were not acknowledged," and the mother agrees.
Habit 4: Invest in the End	I then passed on this information to my manager and let the mother know I would have the information passed along and I encourage her to let anesthesia know next time, that she would like any information that she would like not shared with the child to be talked about outside the room.

Analysis of nurses' responses generated descriptions for each of the Four Habits. Habit I: Invest in the Beginning – introductions are an important first step a nurse should take when initiating communication with a parent. Habit II: Elicit the Parent's Perspective – listening, observing, and creating face-to-face opportunities are all means nurses can use to obtain parents' perspectives. Habit III: Demonstrate Empathy – identification and acknowledgement of parents' emotions helps parents to open up and share information and their feelings. Habit IV: Suggestions of a plan of action and next steps after an emotion-focused conversation can help parents to be more comfortable and less anxious. Six of the 11 participants provided a specific reference to

the Four Habits and identified associated outcomes that resulted from their use, as shown in Table 66.

Table 66

Participants' Four Habits Reference with Associated Outcomes

References to Four Habits Use	Connected Outcomes
I used the four habits with a parent	She seemed very appreciative & her anger decreased [*sic*] as we talked with her becoming much more calm and satisfied [*sic*].
I used habits [*sic*] 1-4 within the past week in my nurse-parent communication	She felt these solutions would improve the privacy of the patient & family, and she did not have any thing else to contribute for ideas.
I used the four habits [*sic*] during a discussion with parents	I had their son as a patient the next 3 nights and we worked through their frustrations together, and although the situation did not change, I could tell they appreciated when I was there.
I've used it (Four Habits) every day!	Listening to family concerns has helped open up the parents.
I used the four habits [*sic*] method	The four habits [*sic*] approach was very useful and helped to alleviate anxiety in this family.
After using the techniques of the four habits	Parents revealed that they were more upset because they were stressed from not knowing what was wrong and because they were exhausted.

Additional Findings

In addition to demographics collected prior to training, participants were asked several questions about the training program that addressed their expectations, overall training usefulness, quality of the training, recommendations or suggestions, and if they would recommend the training program to others. Responses, frequencies, and a summary of these findings are provided in this section.

Expectations for Training

After the participants completed their treatment or control sessions, they were asked to evaluate their pre-study expectations (i.e., eight expectations provided and an "other" category). Three categories were provided for their response: exceeded, met, and not met. Expectations for 22 of the 35 participants (62.8%) were either exceeded or met as shown in Table 67.

Table 67

Expectations for Training Program

Response	Frequency	Percent
Exceeded	12	34.3
Met	10	28.6
Unmet	13	37.1

Expectations for all 21 participants involved in the treatment (100%) were either exceeded or met. All of 13 participants whose expectations were not met were in the control group. The additional control group participant reported their expectations had been met.

Usefulness of training. After the participants completed their treatment or control sessions, they were asked to evaluate the usefulness of the training. Eighteen of the 35 participants (51.4%) found the training program very or quite useful, as shown in Table 68.

Table 68

Usefulness of Training Program

Response	Frequency	Percent
Very useful	8	22.9
Quite useful	10	28.6
Somewhat useful	3	8.6
A little useful	1	2.9
Not at all useful	13	37.1

Eight of the 21 participants involved in the treatment sessions rated the program to be very useful (38.0%), 9 of the 21 participants rated the program quite useful (42.8%), 3 of the 21 participants rated the program somewhat useful (14.2%), and 1 of the 21 participants rated the program a little useful (4.7%). Thirteen of the 14 participants involved in the control sessions rated the program as not at all useful (92.8%) and 1 participant rated the program as quite useful (7.1%). Useful aspects of the training include being able to practice and observe the communication in practice, the simulated training with the parent and debriefing, the card with the habits on it, and hearing about a brand new approach for having emotional conversations with parents. Approximately six-eight weeks after the final training session, participants involved in the control group were offered three different versions of the intervention by way of email invitations sent by the research coordinator. The three version were (1) a full one-hour session in the education testing center with standardized parent, (2) 30-minute session in a hospital education room without standardized parent, and (3) 15-minute inservice-type session in a unit break room or education room in the hospital. Several contact attempts were made by the research coordinator. To date, none of the fourteen participants in the control group have participated in the training sessions.

Usefulness of standardized patients in nurse-parent communication training.

Simulation and standardized patients as parents were an integral components of the study. Three out of four nurses (76.1%) explicitly acknowledged simulation to be one of the most useful aspects of their training experience shown in Table 69.

Table 69

Simulation Identified as Useful in Training

Response	Percentage
Nurse's referenced simulation activities	16 nurses of 21 nurses = 76.1%
Simulation or *simulated* in response	8 nurses of 16 nurses = 50%
Simulation-related terminology in response: - Being able to practice & observe the communication in practice - Experience with anxious parent - Role play and regrouping with mother afterwards - Staged parent nurse interactions, being able to watch and participate - Verbal practice - Role play for practice - Debrief of the scenario and relating it to everyday practice - Hands on training	8 nurses of 16 nurses = 50%

Review of recorded sessions revealed the significant role the standardized patient as the mother served in creating a real, challenging, and emotion-filled experience. Nurses appreciated the authenticity the standardized patient as a parent brought to the interactive case scenario illustrated in Table 70.

Table 70

Authenticity of Standardized Parent Noted by Participants

Participant Comments
- You're impressive. That is amazing. I almost wanted to cry with you. - It did not feel like role playing as I expected. - It was very realistic. Like exact conversations I have had on the floor. - You're a good actress. It felt really real.

A standardized patient in the role of a parent was an integral component in preparing nurses for emotion-focused conversations with parents. Standardize patients can provide nurses with real experience in having difficult conversations with parents. Future communication training and research with nurse, parent (real and standardized patients), physician dyads, and the nurse-parent-physician triad could be useful in interprofessional education and subsequent clinical practice. An example of the program's usefulness provided by one of the participants: "I don't feel like I really had any training about talking about emotions or having deep conversations, so that is useful taking this training. I think watching the simulation and participating in it was VERY useful!" The least useful aspects of training include the short time available to cover the four habits, more time necessary to read and practice the model to improve confidence in applying it to nursing practice, and few examples were provided.

Quality of the training program. After the participants completed their treatment or control sessions, they were asked to evaluate the overall quality of the training program. All of the participants involved in the treatment sessions rated the program excellent, very good, or good as shown in Table 71.

Table 71

Quality of the Program

Response	Frequency	Percent
Excellent	2	5.7
Very good	15	42.9
Good	6	17.1
Fair	7	20.0
Poor	5	14.3

Two of the 21 participants involved in the treatment sessions rated the quality of the program excellent (9.5%), 15 of the 21 participants rated the program very good (71.4%), and 4 of the 21 participants rated the program good (19.0%). Two of the 14 participants involved in the control sessions rated the program as good (14.2%). Seven of the 14 participants in the control sessions rated the program fair (50.0%) and 5 of the 14 rated the program as poor (35.7%).

Recommend training. After the participants completed their treatment or control sessions, they were asked if they would recommend the training to others. Twenty-seven of the 35 participants (77.1%) would recommend the training program to others as shown in Table 72.

Table 72

Participants Recommend Training

Response	Frequency	Percent
Yes	27	77.1
No	8	22.9

Twenty of the 21 participants (95.2%) in the treatment group would recommend the training to others and one participant would not (4.7%). Six of the 14 participants

(42.8%) in the control group would recommend the training to others. Eight of the 14 participants (57.1%) in the control group would not recommend the training to others.

Suggestions or recommendations. After the participants completed their treatment or control sessions, they were asked to provide suggestions or recommendations about the training. Suggestions or recommendations provided by participants in the control group were to include a different video and provide the training to everyone. Nurses in the control group, as noted earlier, were offered the opportunity to receive the training in the original or two additional formats. None of the 14 nurses in the control group participated in any of the additional training sessions. Suggestions and recommendations of participants involved in the treatment group include providing booklets for participants to take home, training would be very useful during hospital orientation, including additional simulation scenarios, more time, and providing videos of parent-nurse interactions that are appropriate and inappropriate in addition to having all nurses go through the simulation.

CHAPTER FIVE: DISCUSSION AND CONCLUSION

The stressful and often emotion-filled experience parents endure when their child is hospitalized can test health care providers and the systems they work in if they are not prepared to assist parents through difficult and emotional times. Quality of care and parental satisfaction are important measures and are a direct reflection of providers' level of care and success in facilitating parents' pursuit of information about their child. Helpful relationships between parents and providers that involve caring, warmth, respect, and kindness can improve parental satisfaction (Ammentorp et al., 2005; Wills & Wills, 2009). With repeated exposure, contacts, interactions, and experience over time, trust between patients-providers and parents-providers can develop (Thorne & Robinson, 1988). Interactions that lead to caring nurse-parent relationships require nurses to have a number of skills and abilities that may require experience and may not develop until later in their professional development (Benner et al., 2009). Nurse-parent communication plays an integral role in the numerous contacts and interactions nurses have with parents who are often stressed and full of emotion when their child is hospitalized. Regrettably, nurses' understanding about how to work with parents who express emotions comes from years of experience. Newly licensed nurses may have limited experience and may or may not have had communication education and, therefore, be less prepared for emotion-focused conversations with parents. This study provided evidence that a brief intervention involving communication content, an interactive experience, and reflection can improve new nurses' preparation for some of the more difficult conversations they may have with parents.

Specific research aims for this study were to: (1) evaluate the effects of a brief Four Habits communication training intervention for newly licensed pediatric nurses on their level of preparation for emotion-focused conversations with parents, and (2) evaluate participants' application of the Four Habits communication training in their clinical practice. Findings from this study provide evidence that a brief one-hour intervention using a current validated communication model, utilizing a simulated conversation with a distressed parent followed by a formal debriefing session assists newly licensed nurses in their self-perceived level of preparation for difficult conversations with parents. The following section provides a discussion on how the research aims were met, how the study's findings relate to current literature, limitations of the study, and future research implications.

Significance of the Brief Intervention for Newly Licensed Nurses

Newly licensed nurses involved in this brief intervention reported significant improvements in their perceived preparation for emotion-focused conversations with parents in four of the five areas measured which resulted in significant improvements in their calculated Total Preparation score. Nurses' scores were improved pre to post assessment in their sense of Preparation, Communication Skills, Relationships, and Confidence. Yet, newly licensed nurses involved in the study did not demonstrate a decrease in their Anxiety level as expected. These findings provide data that support the hypothesis that nurses taking the communication training would show significant improvements in one or more of the individual outcome scores when compared to the control group.

These findings were similar to results from the innovative PERCS training program that has taken place at Children's Hospital Boston for a number of years (Meyer et al., 2009). In one report, the PERCS training program took place over a full day for 101 participants from a variety of disciplines (i.e., physicians, nurses, social workers, psychologists, and chaplains). The PERCS training program used an experiential learning paradigm involving videotaped material, lecture and discussion, and case simulation with professional actors serving as patients and family members to improve pediatric critical care practitioners' communication skills and relational abilities in critical care (Meyer et al., 2009). In contrast, although similar methods were used, the brief intervention used in this current study was structured around an established communication model with empathy and emotions the focus (Stein et al., 2011). As one of the participants in the current study expressed after participating in intervention, "I don't feel like I really had any training about talking about emotions or having deep conversations." When profound conversations involving emotions occur, respect, trust, and relationships have tremendous potential to develop.

Differences between the PERCS program and this brief intervention were evident; however, similarities between the two programs were also apparent. Participants' perception of improvements in the PERCS study included improvement in all five of the items measured: Preparation, Communication Skills, Relationships, Confidence, and Anxiety (Meyer et al., 2009). Improvements perceived in the current study were evident in four of the five areas: Preparation, Communication Skills, Relationships, and Confidence. Participant's self-appraisal of Anxiety did not reveal improvements. In the study reported by Meyer et al. (2009), participants' preparation scores had the greatest

increase; moderate increases were noted in Communication Skills, Confidence, and Anxiety; and the least amount of improvement or increases were noted in participants' ability to develop and maintain relationships. Unlike the PERCS program, improvements in anxiety were not found in the current intervention study. Anxiety may be a facet of emotion-focused conversations that requires newly licensed nurses to practice the Four Habits more in order to obtain the experience necessary to reduce their anxiety. As Meyer et al. suggests based on the results from the PERCS program, small reductions in participants' anxiety or increases may reflect participants' understanding of the complexity of difficult conversations. Connections between participants' communication skills and relational abilities may be difficult to train in a one-day training session.

In addition to immediate follow-up, Meyer et al. (2009) also followed up with their participants five months later. Their findings revealed sustained improvements over time in four of the five areas with Relationships the only one which did not improve. The current study did not employ the use of quantitative assessment and follow-up beyond the immediate post-intervention period. Therefore, it is not known whether or not participants in the current study sustained their level of improvement over time. However, a majority of nurses involved in the intervention did report specific examples of implementing the Four Habits when working with parents in clinical settings. Nurses described conversations with parents based on the Four Habits during which parents expressed more and opened up, were appreciative, and generally felt that they were heard. It is reasonable to expect continued practice and experience in using the Four Habits would positively influence nurses' ability to develop relationships with parents. Additionally, nurses' continued awareness of the Four Habit communication training

provided by a laminated card summary would facilitate improvements in nurses' confidence, communication skills, and overall preparation for emotion-focused conversations with parents.

In another study conducted in Italy, researchers adapted the PERCS program and results had similarities and differences from those found in this brief intervention study (Lamiani et al., 2011). Adaptations for the Italian-PERCS program included an abbreviated training session of four hour instead of seven-hour/full-day, representation of a family members by faculty were not used, and trained clinical psychologists were used as patients and family members instead of professional actors. Participants in that study included 129 nurses, psychosocial professionals and others. A review of the collective groups' findings demonstrated improvements in Preparation, Communication Skills, and Confidence. When the results were examined for the specific disciplines involved, improvements for both nurses and physicians were reported in Preparation, Confidence, and Communication Skills items. Nurses' level of anxiety was not reported as an area of improvement, a similar finding to the current study reported here. Difficult conversations and breaking bad news to patients typically has an effect on providers' emotions and can produce or exacerbate providers' anxiety (Fallowfield & Jenkins, 2004; Girgis & Sanson-Fisher, 1995; Rassin, Levy, Schwartz, & Silner, 2006). Finding an effective method of assisting providers when working with parents as emotions are expressed is possible in full-day and half-day trainings without a comparison group. However, use of a control group as was used in this study, strengthened the findings that even a brief intervention was effective.

Adaptation of the Four Habits Model in this brief intervention study provided nurses with a straightforward way to organize their thinking, a technique of approaching, and a process to use when having emotion-focused conversations with parents. Newly licensed nurses as advanced beginners typically do what they know how to do and what they see as important (Benner et al., 2009). Similarly, information processing theory informs our understanding of how newly licensed nurses anticipate, select, and construct knowledge based on the way they handle information (Greenwood, 2000; Tomlinson, 1981). Information in the form of parents' expressed emotions may or may not be processed effectively by newly licensed nurses. This is particularly common if the nurse does not perceive parents' expressed emotions as important or does not know how to communicate effectively when parents express emotions.

The adapted version of the Four Habits Model provides nurses with a useful method of organizing their thinking about information they may not be familiar with, parents' expressed emotions. The original form of the Four Habits Model contains 30 techniques and examples useful in physician-patient communication interviews (Stein et al., 2011). These were synthesized and reduced to 11 techniques and examples in the abbreviated form of the Four Habits Model used in this study. The Four Habits were pared down to provide a basic procedure newly licensed nurses could use when having emotion-focused conversations with parents. An abbreviated overview of the adapted Four Habits was created in the form of a two-sided laminated card which was provided to participants involved in the intervention of this study. The laminated card was a reportedly useful tool that participants were able to attach to their badge and could be referred to as needed. This usability was evidenced in a participant's response when

asked to identify what they found useful in the training: “the card with the habits on it. It will be a good tool to glance at while at work.” As reported in a previous study, when nursing students were asked about their expectations about a one-hour nurse-parent communication session, a large number of students identified their desire to have the ideal words to say to parents instead of a way to organize their thinking (Fisher et al., 2012). It would be difficult to teach newly licensed nurses about all of the appropriate words to use with parents and the most effective responses when parents express emotions. However, helping nurses with a framework or structure of thinking about how to communicate with parents could avoid problems such as conflict that can develop from poor communication in the health care setting (Brinchmann et al., 2002; Griffin, 2003a, 2003b).

Finally, another aspect that proved to be helpful in the Four Habits communication training program was assisting nurses to get over the fear and anxiety related to the process of approaching parents. The adapted Four Habits Model provided nurses with a method useful in guiding newly licensed nurses how to elicit parents’ perspectives and listen to the parent’s perspective, something that is often missed and something that is important to parents (Dokken, Simms, & Cole, 2007; King, 2009; Montagnino & Ethier, 2007; Wills & Wills, 2009). In fact, in parent-provider interactions in which providers communicate minimally and dictate how things are done add to parental stress (Dokken & Ahmann, 2006).

The minor semantic change made for this study in the second habit from “Elicit the Patient’s Perspective” to “Elicit the Parent’s Perspective” encourages nurses to consider a new way to make contact with parents during emotionally charged or difficult

times. Nurses may learn a great deal about how to provide patients, parents, and their patient's family with information. Helping nurses with understanding the importance of eliciting parents' perspectives and gaining the necessary knowledge about the skills necessary has proven to be a complex, yet rewarding undertaking.

Interaction Effects of Level of Experience and the Brief Intervention

In this study, the level of experience in nursing (i.e., length of time as a RN) had no effect on nurses' preparation for emotion-focused conversations with parents for nurses who participated in the brief intervention. The expectation that experience would have some influence comes from research by Benner et al. (2009); Marshburn, Engelke, & Swanson (2009); Olson (2009); and Wangensteen and colleagues (2008). Experience provides professionals with new knowledge and information to refer to which often can be useful in practice (Benner et al., 2009). It was predicted in this study that nurses with less experience (less than 12 months as an RN) would show greater improvement in all five individual areas as well as their Total Preparation score when compared to nurses with greater experience (12 or more months as an RN). Yet, results were similar for both experience level groups involved in the treatment in the items Preparation, Communication Skills, Relationships, and Confidence. In this study, it may have been premature to train nurses who are relatively homogenous in their level of experience. That is, despite the range of 24 months, the two groups of nurses involved in the training are both considered to be advanced beginner nurses (Benner et al., 2009). On the other hand, the training was useful for all of the nurses involved in the intervention, as detailed in the findings section and previous portion of this section of this paper. Expanded use of the intervention with nurses at various levels of experience, including nurses with more

than 24 months experience, may provide additional information useful in determining when this form of training would be best to implement. Additionally, adapting the intervention for nursing students may prove to be beneficial in helping future nurses prepare themselves for emotion-focused conversations with parents. Getting over the fear of communicating with parents by being exposed to role-play activities with real parents may be useful (Fisher et al., 2012). However, it is not clear if experience with real parents and role play activities facilitate nurse-parent communication in the hospital and community settings.

Experience, competence, and development during the first year of nursing and beyond vary greatly among nurses (Marshburn et al., 2009; Olson, 2009; Wangensteen et al., 2008). Nurses with less experience involved in this study reported their level of anxiety to be less than nurses who had more experience at pretest assessment. However, nurses with less experience reported their level of anxiety to be a relatively consistent level at posttest assessment when compared to their pretest. Nurses with more experience reported their level of anxiety to be higher at pretest assessment and significantly lower at posttest. Nurses with more experience as a nurse could be expected to have improved their confidence enough to reduce their anxiety because of the training experience. Nurses who can handle problems tend to be more confident in their abilities to communicate with patients, family members, and physicians (Marshburn et al., 2009). Nurses with less nursing experience may have been overly confident which might have been reflected in their self-appraisal of a lower level of anxiety prior to the training. These same nurses with less experience might have realized they under assessed the complexities and seriousness of emotion-focused conversations with parents, a possibility

the authors reported in both PERCS and Italian-PERCS studies (Lamiani et al., 2011; Meyer et al., 2009). Another explanation for the differences in nurses' perception of their anxiety level may be due to newly licensed nurses' experience in an uncertain and chaotic environment. An important identified need nurses have in their first year of experience is the need to view all of their experiences as learning experiences (Wangensteen et al., 2008). If a new nurse were to have a negative experience with a parent in the past and received negative feedback from their peers, this feedback may reinforce the new nurse's anxiety about difficult conversations.

Nurses with less experience are likely to have been more critical about their own performance when discussing their experience in the debriefing session among their peers. Nurses with more experience could have felt their knowledge and understanding about working with parents who express emotions reinforced during the debriefing session with their peers. However, familiarity with the unit one works on, personal confidence in what one is doing, and a sense of being more comfortable on the unit tends to occur for nurses by the time they have six months experience (Olson, 2009). Nurses' familiarity with parents they usually work with may have positively influenced anxiety scores for nurses with more experience because of the realistic interactive experience that was similar to practice on their unit. Previous experience was not part of the demographic data collected for this study, other than the levels of nursing and pediatric nursing experience. Advanced beginners experience many challenges and frustrations as they gain experience necessary for professional development (Benner et al., 2009).

Practical Application of Four Habits Content with Actual Parents

Stories provided by nurses in the intervention group up to five weeks after the training revealed that nurses used the Four Habits with parents in clinical practice. Clear delineations between each of the Four Habits were not evident in the majority of nurses' descriptive responses; however, the essence of each of the Four Habits was identified. Four Habits were exemplified by nurses' reporting their understanding of the importance of introducing oneself, obtaining parents' perspectives, being open to parents' expressed emotions, and concluding the conversation with negotiated next steps or a plan of action. Although the majority of the nurses reported their use of the Four Habits with parents by responses such as "I used the four habits method" and "I used the four habits during a discussion with parents," most reported of use of the Four Habits in a more general and non-specific manner. That is, they often referenced the overall goal of the Four Habits by allowing the parent to speak and share their concerns without trying to fill the conversation with information from the health care point of view. The parent's perspective and the emotional response the parent expressed were perceived as information by the nurses and thus were incorporated into nurses' care. In this case, none of the Four Habits appeared to be used in isolation of the others. Taking some time to listen and discuss issues of importance for parents, particularly when emotions are involved, is an effective use of time for nurses. An outcome identified by several nurses involved in the brief intervention was how the Four Habits facilitated the parents' process of opening up and sharing their concerns with nurses. Finding practical ways in helping parents to open up and share their feelings and concerns can help develop trust, respect, and ultimately healthy relationships between nurses and parents. While the majority of

nurses reported they had received previous communication training, most nurses sharing their previous training did not focus on communication with parents who expressed emotions. Instead, nurses identified AIDET as the most common form of communication training they had received (Studer Group, 2010; Studer et al., 2010). The use of AIDET when information exchange alone is the focus may be particularly useful. However, the use of the Four Habits might be best used when emotions are involved, expressed, or need to be expressed. Only two of the nurses involved in the study reported AIDET was the form of communication training that had prepared them for emotion-focused conversations with parents. Nurses experienced with the use of both communication models may prove to be better prepared nurses in the pediatric setting. Further study may be necessary in an effort to determine each of the models' optimal use in nurse-parent communication.

A consistent positive theme evident through participants' feedback in the study relates to the effectiveness and usefulness of the simulated conversation activity, either experienced or observed. Three out of four nurses (75%) involved in this Four Habits communication training study specifically stated the simulation was one of the most useful aspects of their training experience. Review of video and audio-recorded sessions revealed the significant role the standardized patient/parent as the mother served in creating a real, challenging, and emotion-filled experience. Realism and believability are important aspects when working with emotion-filled communication training issues, particularly when anger is the primary emotion (Rosenzweig et al., 2008). Relating to patients and their parents takes more than teaching a nurse to communicate. Communication training with simulation may help students with specific communication

skills; however, using simulation to help students learn about some of the less obvious complexities of communication, empathic communication, and building relationships are additional priorities worth pursuing (Wear & Varley, 2008). In this study, nurses appreciated the authenticity the standardized patient brought to the interactive case scenario. Standardized patients can provide nurses with real experience in having difficult conversations with parents. In the right circumstances and with appropriate training, standardized patients can assist in bringing a parents' perspective to light and helping nurses develop a sense of empathy and understanding of a parent's point of view. Future communication training and research with nurse, parent (real and standardized patients), and physician dyads, and the nurse-parent-physician triad could be useful in interprofessional education and subsequent clinical practice. Parents are being asked to rate their nurses' courtesy, respect, explanations, and listening in the Hospital Consumer Assessment of Health Care Providers and Systems surveys following their child's hospitalization (Studer et al., 2010), therefore, we must spend time educating nurses and nursing students if improvements are expected in these areas.

"Simulation," whether it is high fidelity, low-fidelity, or somewhere in between, "it is all simulation," was Dr. Geoffrey T. Miller's keynote presentation title for the opening session of the 11th Annual Association of Standardized Patient Educators (ASPE) Conference held in San Diego, California, June 3–6, 2012. That is to say, it is not as important what we call an activity that involves a person or device as it is to focus on the outcomes and effectiveness of the methods and process. Dr. Miller went on to say that shared attributes for all simulation include integration, practice, and feedback. Using standardized patients for teaching and learning communication has been successful in a

number of areas. Nurses are in a unique position to make a difference. Yet, traditional communication training methods may not be effective in helping new nurses learn how to communicate and practice having emotion-focused conversations with parents.

Fisher and colleagues (2012) used real parents to help nursing students gain a potentially new perspective from a parent and reduce their fear of talking with parents. Formal communication training knowledge, skills, and behaviors were not the primary focus. Large groups of students in most nursing programs require numerous simulated sessions that push the cost of such a program over existing budgets, particularly with scenario development and the use of standardized patients (Rosenzweig et al., 2008). The feasibility in using simulation during the training of pediatric health care providers in disclosing medication errors involving parents was the primary focus for Wayman and colleagues' work (Wayman et al., 2007). Even with the many issues that surround this form of simulation training and education, simulation use in parent-nurse communication training may still be worthy of serious consideration. Innovative methods of communication training are limited for undergraduate nursing students (Fisher et al., 2012), graduate nursing students (Rosenzweig et al., 2008), and practicing licensed RNs (Meyer et al., 2009; Wayman et al., 2007), and of more of these need to be developed and disseminated.

Limitations

There were several limitations in this study. Quantitative and qualitative assessment instruments relied on self-evaluation, and self-reporting mechanisms have inherent weaknesses such as respondents give expected or socially desirable answers, lack truthfulness, misunderstanding of question, and instability of respondents' opinions

and attitudes (Singleton, 1998). These were controlled by removing all personally identifiable information from survey data, encouraging participants to respond honestly and truthfully, and reassurance that all of the data would remain with the research coordinator in a safe and secured location. Additionally, participants were reminded all personal identification would be removed prior to being reviewed for final analysis.

The sample target required to have the power to test the hypotheses was met; however, there were a number of issues that led to the small sample that comprised this study. Disruption in posting of recruitment flyers, reliance on indirect recruitment via word of mouth, and timing of the year (holidays) contributed in part to the small sample. Issues related to recruitment led to a number of changes by the hospital's Shared Governance Council to more effectively address research recruitment and related issues in the future. Recruitment involving face-to-face meetings between the research coordinator and nurse managers with potential nurse participants proved to be more productive than posted flyers alone. Overall, 71 nurses registered for the study and 35 participated in the study (49.2%). Some of the reasons potential participants provided for not attending the training sessions included: child care not available; work schedule (e.g., working 4 nights in a row, switching shifts, difficulty in functioning in the morning after shift); unexpected duties (e.g., shift running late); car trouble (e.g., dead battery, flat tire); illness (e.g., called in sick for shift); and hesitation in participating because training sessions were scheduled at end of the shift or just before shift. Additional pre-recruitment information gathering and discussions with nurse managers and nurses might have been helpful in more effective selection of study dates and times.

Nurses self-selected involvement based on their own interest in the training, scheduling availability, and prior experience working with the PI (i.e., nurses' identification of previous nursing student-parent communication training conducted by PI). In an effort to control for this, recruitment efforts were systematic which involved numerous PI contacts with unfamiliar nurses in an effort to avoid influences informally or potentially characterized as favoritism or friendly familiarity.

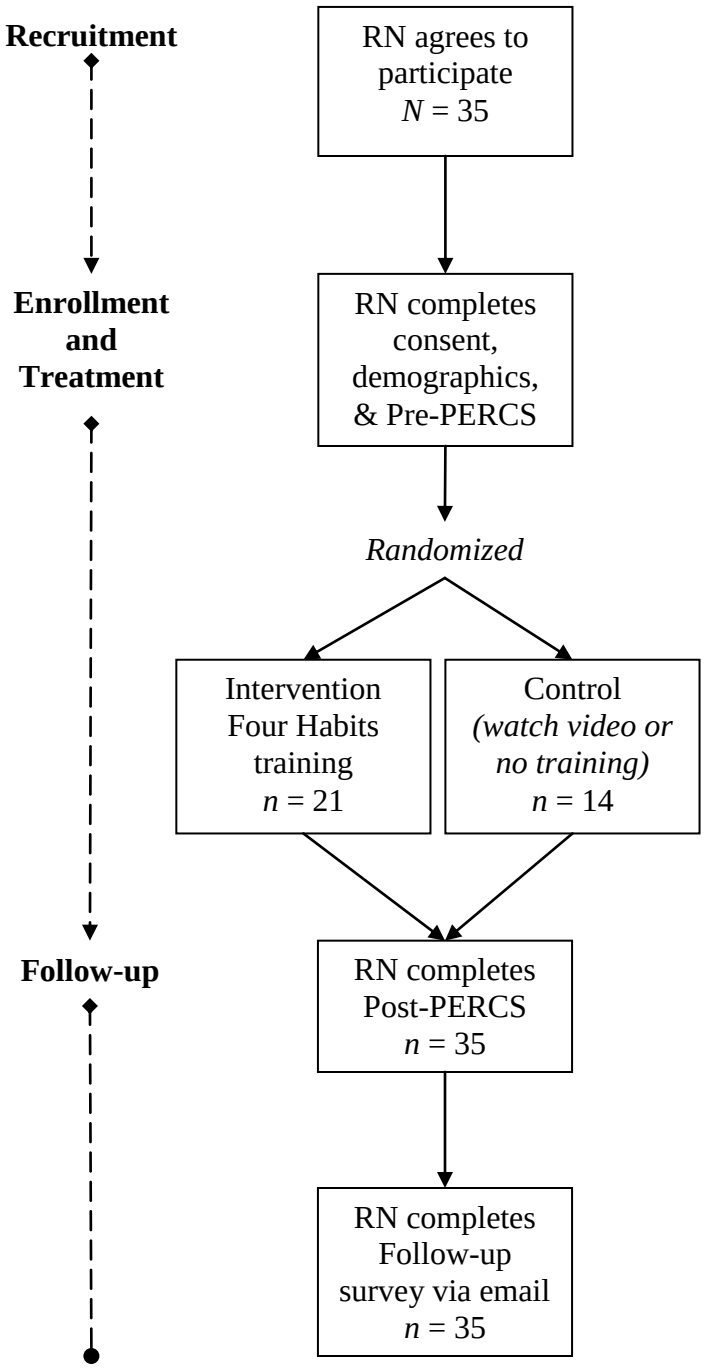
A number of efforts were made to reduce the potential test and test-retest effects including the PI's emphasis on the honesty and integrity of participants' responses and implications of the study's outcome in future education, research, and practical clinical use. Setting the formal tone and creating a professional environment was important for the PI and research coordinator from the beginning to ensure the participants would be in a safe and confidential place where they could be honest and truthful in their responses.

Future Research

Based on the findings of this study, a brief intervention designed to introduce the use of Four Habits and improve nurses' communication with parents who express emotions shows promise. Nurses involved in the treatment sessions showed significant improvements in four out of five areas of preparation for emotion-focused conversations with parents measured as a part of this study. The long-term effects and sustainability of the training were not examined or measured and are therefore not known. Follow-up five or six months after the intervention, similar to the five-month follow-up implemented by Meyers and colleagues (2009), is recommended for future research initiatives in an effort to determine sustainability over time. Innovative and creative methods of communication training with nursing students and nurses in practice are needed if nurses are expected to

meet the current and future communication competencies in the area of communication and rapport with families (Berkow et al., 2008). Simulation training, education, and research with the use of standardized patients serving as parents may be a new answer to the old question of how we provide nurses and nursing students with real-life experience without relying on trial-and-error in the hospital. The incorporation of standardized patients serving as parents in current and future interprofessional training and research may help to bring family-centered principles to life. AIDET communication is a popular form of communication training being used in hospitals in the United States (Studer Group, 2010; Studer et al., 2010). The Four Habits Model is a useful model for training communication between physicians and patients in the United States (Stein et al., 2005) and in Norway (Gulbrandsen et al., 2008). Findings from this study suggest that AIDET is not effective in preparing newly licensed nurses for emotion-focused conversations with parents and an adapted version of the Four Habits Model does help nurses prepare for these difficult conversations involving parents' expressed emotions. Future research studies and educational efforts should examine the comparative effectiveness of AIDET and the Four Habits on a variety of provider-parent communication situations in an attempt to determine efficacy of both models. Models of care centered on relationships and relational care inform future health care (Frankel, 2004; Suchman, 2006). Results from this study suggest the use of effective communication skills, such as eliciting parents' perspectives and empathy, may result in increased parent satisfaction with care. Teaching nurses how to use a few useful habits for nurse-parent communication during an emotionally charged time is an effective way to shed light on an invaluable relationship in health care, the nurse-parent relationship.

APPENDIX A: RESEARCH DESIGN AND DATA COLLECTION



A Brief Intervention to Improve Emotion-Focused Communication Between Newly Licensed Pediatric Nurses and Parents

Are <u>YOU</u> interested in participating in a unique project promoting quality parent-provider communication critical in patient- and family-centered care?

WHAT: This study will evaluate the impact of a one-hour intervention with newly licensed pediatric nurses intended to improve their ability to participate in emotion-focused conversations with parents

WHO: Newly licensed pediatric nurses – Nurses with an RN license for up to two years (i.e., RNs who have had their RN license for 0-24 months)

WHERE AND WHEN: The study will take place on *(actual date[s] to be included in final advertisement flyer)* at the Clinical Skills Education and Testing Center on the OUHSC campus (6th floor of Garrison Tower)

WHY: Nursing is in a unique position to capitalize on partnering opportunities with parents because of nurse's integral role in pediatric patient care – yet, educational opportunities focused on nurse-parent communication for practicing pediatric nurses are limited or non-existent

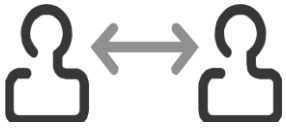
HOW: <u>Participation</u> – arrangements, registration, and related questions contact: Michelle D. Wallace by email michelle-wallace@ouhsc.edu or by telephone: (office # provided)
<u>Questions about the study</u> – contact: Mark J. Fisher, RN, Doctoral Candidate, MS – Principal Investigator by email: mark-fisher@ouhsc.edu or by telephone: (cell/mobile # provided)

(Submitted version for OUHSC and IUPUI IRB approval)

Figure B1. Original study recruitment flyer.

A Special Opportunity from your OUMC Shared Governance Research Council

A Brief Intervention to Improve Emotion-Focused Communication Between Newly Licensed Pediatric Nurses and Parents



Are YOU interested in participating in a unique project promoting quality parent-provider communication critical in patient- and family-centered care?

WHAT: This study will evaluate the impact of a one-hour intervention with newly licensed pediatric nurses intended to improve their ability to participate in emotion-focused conversations with parents

WHO: Newly licensed pediatric nurses – Nurses with an RN license for up to two years (i.e., RNs who have had their RN license for 0-24 months – licensed on or after December 1, 2009 and before December 1, 2011)

WHERE AND WHEN: The study will take place on **Friday, December 2** or **Friday, December 9, 2011** (your choice) at the Clinical Skills Education and Testing Center on the OUHSC campus (6th floor of Garrison Tower)

WHY: Nursing is in a unique position to capitalize on partnering opportunities with parents because of nurse's integral role in pediatric patient care – yet, educational opportunities focused on nurse-parent communication for practicing pediatric nurses are limited or non-existent

HOW: Participation – arrangements, registration, and related questions contact: Michelle D. Wallace by email michelle-wallace@ouhsc.edu or by telephone: (office # provided)
Questions about the study – contact: Mark J. Fisher, RN, Doctoral Candidate, MS – Principal Investigator by email: mark-fisher@ouhsc.edu or by telephone: (cell/mobile # provided)

The University of Oklahoma Health Sciences Center IRB approved study #16053
Indiana University IRB approved study #1109006673

Contact Janice Newton at (number provided) with questions
(OUMC Shared Governance Research Council)

Figure B2. New study recruitment flyer.

Consent Form
University of Oklahoma Health Sciences Center (OUHSC) and
Indiana University Purdue University Indianapolis (IUPUI)
A Brief Intervention to Improve Emotion-Focused Communication Between Newly Licensed Pediatric Nurses and Parents
Mark J. Fisher, MS, RN – Principal Investigator

This is a research study. Research studies involve only individuals who choose to participate. Please take your time to make your decision. Discuss this with your family and friends.

Why Have I Been Asked To Participate In This Study?
You are being asked to take part in this trial/study because you are a pediatric Registered Nurse at the Children's Hospital at OUMC with 0-24 months of post-licensure experience (months with an RN license).

Why Is This Study Being Done?
The purpose of this study is to evaluate the impact of a brief intervention with newly licensed pediatric nurses intended to improve their ability to participate in emotion-focused conversations with parents. The outcome is expected to be a useful intervention effective in preparing nurses for emotion-focused nurse-parent communication when interacting with parents in the clinical setting.

How Many People Will Take Part In The Study?
About seventy people (nurses) will take part in this study worldwide/nationwide. All of these individuals will participate at this same location.

What Is Involved In The Study?
All participants will be asked to complete a scheduling request, an enrollment and training session, post-study questionnaire, and follow-up survey. The scheduling request involves selecting a time from a set of choices when you will be scheduled to participate in the enrollment and training session. The enrollment session includes an overview of the study provided by the PI, completion of the consent form, demographics form, and pre-study questionnaire. The enrollment process should take a total of approximately 15 minutes to complete. In addition to these activities, participants will be randomized into a treatment or control group. Participants in the treatment group will complete a one-hour communication training session. Participants in the control group will complete a one-hour non-training session*. All participants will complete a post-study questionnaire after their session and will take approximately 15 minutes to complete. The follow-up survey will be emailed to all participants two weeks after completing the post-study questionnaire and is estimated to take approximately 15 minutes to complete.

*Note: All participants randomized into the control group will be provided an opportunity to complete the communication training session at a later date (approximately six weeks after the initial research sessions).

How Long Will I Be In The Study?
We believe that you will be in the study for approximately four to six weeks from the point of completing this consent form to the point you complete and mail in the follow-up survey.
You can stop participating in this study at any time. However, if you decide to stop participating in the study, we encourage you to talk to the researcher first. There may be unanticipated

situations under which your participation may be stopped by the researcher without regard to your consent. If the researcher feels your workload demands requires your time and attention and it is in the best interest to stop participation, the researcher may terminate your participation without your consent.

What Are The Risks of The Study?
The researcher does not expect any risks to you from this study. Occasionally, participation in interactive learning experiences can raise issues that may be distressing or stressful.

Are There Benefits to Taking Part in The Study?
Participating in this study may increase your knowledge and understanding some of the challenges faced in nurse-parent communication and a method to use during this type of conversation. You may also be able to use the information and knowledge you receive in being a participant in the clinical patient care. Additionally, you will assist in providing the investigator with useful information that could be applied to future communication-focused clinical training and pre-service education sessions. We hope that the information learned from this study will benefit other nurses, patients, and parents in the future.

What Other Options Are There?
You may choose not to participate in the study.

What About Confidentiality?
Efforts will be made to keep your personal information confidential. You will not be identifiable by name or description in any reports or publications about this study. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law.

There are organizations that may inspect and/or copy your research records for quality assurance and data analysis. These organizations include the University of Oklahoma Health Sciences Center (OUHSC) Institutional Review Board and the Indiana University Purdue University at Indianapolis (IUPUI) Institutional Review Board.

The training sessions will be digitally audio and video recorded. The recordings remain confidential with the researcher (Primary Investigator), researcher assisting with the study (Sub-Investigator), and the person assisting with the project (Research Coordinator).

We will not share any of the information you provide for this study with your employer.

What Are the Costs?
No expenses or costs are expected for participants. There is a possibility you may incur costs for transportation, parking, and other related expenses related to attending the training session(s).

What Are My Rights As a Participant?
Taking part in this study is voluntary. You may choose not to participate. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. If you agree to participate and then decide against it, you can withdraw for any reason and leave the study at any time. You may discontinue your participation at any time without penalty or loss of benefits, to which you are otherwise entitled.

You have the right to access the medical information that has been collected about you as a part of this research study. However, you may not have access to this medical information until the entire research study has completely finished and you consent to this temporary restriction.

Whom Do I Call If I have Questions or Problems?
If you have questions, concerns, or complaints about the study or have a research-related injury, contact the Mark J. Fisher (Principal Investigator) at the cellular telephone number: (number provided) or office telephone number: (number provided) or Marion E. Broome (Sub-Investigator) at the following office telephone number: (number provided).

If you cannot reach the Investigator or wish to speak to someone other than the investigator, contact the OUHSC Director, Office of Human Research Participant Protection at 405-271-2045. For questions about your rights as a research participant, contact the OUHSC Director, Office of Human Research Participant Protection at 405-271-2045.

Signature:

By signing this form, you are agreeing to participate in this research study under the conditions described. You have not given up any of your legal rights or released any individual or entity from liability for negligence. You have been given an opportunity to ask questions. You will be given a copy of this consent document.

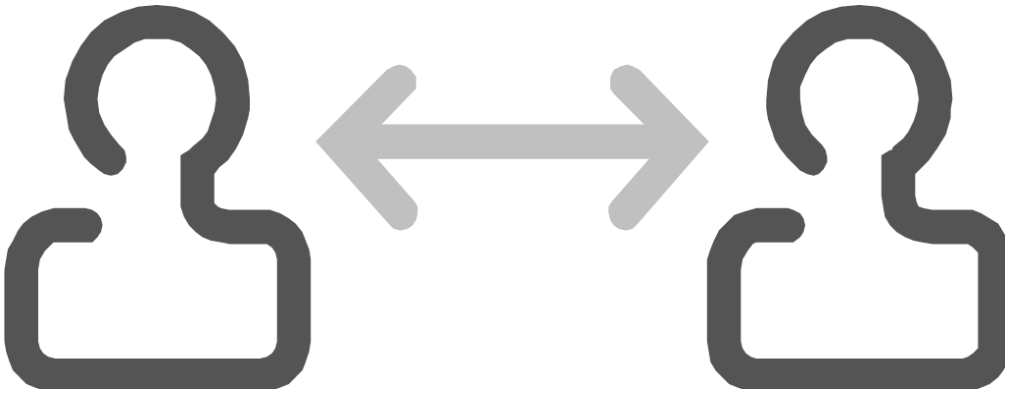
I agree to participate in this study:

_____	_____	_____
PARTICIPANT SIGNATURE (age ≥18) (*Or Legally Authorized Representative)*	Printed Name	Date
_____	_____	_____
SIGNATURE OF PERSON OBTAINING CONSENT	Printed Name	Date

IRB Office Version Date: 09/08/2010

Figure B3. Consent form from University of Oklahoma Health Sciences Center and Indiana University–Purdue University Indianapolis.

A Brief Intervention to Improve Emotion-Focused Communication between Newly Licensed Pediatric Nurses and Parents



Nurse/Participant Training Manual

Mark J. Fisher, MS, Doctoral Candidate, RN
Contact information – email: Mark-Fisher@ouhsc.edu
Cell: (number provided)

Study date: November 18, 2011

The University of Oklahoma Health Sciences Center IRB approved study #16053
Indiana University IRB approved study #1109006673

A Brief Intervention to Improve Emotion-Focused Communication between Newly Licensed Pediatric Nurses and Parents

Nurse/Participant Training Manual – **Four Habits** Nurse-Parent Communication Training

(Frankel & Stein, 1999; Krupat et al., 2006; Stein et al., 2005; Stein et al., 2011)

Learning Objectives:

- Identify and describe the Four Habits and their use in nurse-parent communication
- Describe and discuss process of using the Four Habits in nurse-parent communication
- Apply and evaluate use of the Four Habits in a simulated nurse-parent communication

Teaching/Learning: *(estimated timeline for 60-minute Four Habits communication training)*

20-minutes: Four Habits and the Use of Four Habits in Nurse-Parent Communication
20-minutes: Simulated Nurse-Parent Communication using Four Habits
20-minutes: Debrief, Wrap-up, Questions-Answers, and Review

<u>First 20-minutes:</u> The Four Habits and their use in Nurse-Parent Communication

The Four Habits – Background

- The Four Habits Model has primarily been used in physician-patient communication training

- The Four Habits Model provides a sequential structure of four interrelated yet separate communication behaviors used during physician's medical interviews

- The term "habits" are used to indicate an organized method of acting and thinking in the process of a medical nurse-patient interpersonal exchange

- Each habit is aligned with specific sets of skills and techniques
  HABIT 1: Invest in the Beginning
  HABIT 2: Elicit the Parent's Perspective
  HABIT 3: Demonstrate Empathy
  HABIT 4: Invest in the End

- Goals of the Four Habits for nurse-parent communication training:
  Habit 1) nurse quickly initiates the process of creating rapport with the parent
  Habit 2) nurse elicits parent's concerns and their impact on the parent
  Habit 3) nurse is open to, identifies, and accepts parent's emotions
  Habit 4) nurse concludes conversation to the parent's satisfaction

HABIT 1: Invest in the Beginning – A nurse's actions and behaviors during the initial contact with a parent are influential in creating a positive first impression. Creating rapport quickly is vital in meaningful provider-parent communication that relies on providers drawing out patient's (parents') concerns and setting the patient (parent) at ease during the first few moments of an interaction setting the groundwork for establishing trusting relationships (Stein et al., 2011, p. 3).

- *"The first few moments of the conversation are essential for establishing a trusting relationship and setting the patient (parent) at ease"* (Stein et al., 2011, p. 3).
- *"Being aware of and consciously using nonverbal cues such as facial expression, tone of voice, and proximity requires no extra time and yet can rapidly create an atmosphere that reduces patient (parent) anxiety"* (Stein et al., 2011, p. 3).

Content from "Four Habits Training and Evaluation Checklist"				
HABIT 1: Invest in the Beginning				
	Yes	*No*	*?*	*Notes/Com-ments*
Greets parent in a personal and warm manner				
Attempts to identify problem using open-ended questions				

Habit 1: Invest in the Beginning *(continued)* – applied to nurse-parent communication

Create rapport quickly
- Introductions: use last name and title (i.e., Mrs. Smith)
- Consider cultural background use appropriate
- Gestures, eye contact, and body language

Elicit parent's concerns
- Start with open ended questions
- "I understand there was a situation involving your child. Could you tell me more about that?"

Plan the visit with parent
- Repeat concerns back to check understanding
- Let parent know what to expect
- Prioritize when necessary

HABIT 2: Elicit the Parent's Perspective – Nurses collect information, assesses their patients, and use their knowledge during the process of providing patient care. Nurses' perspectives provide one side of patient care. Parents' perspectives provide another facet of care potentially useful in both patient care and provider-parent

relationships. Addressing patient's perspectives and concerns can assist in clarifying the issues while demonstrating provider's respect and appreciation of parents involvement (Stein et al., 2011). It is reasonable to believe a nurse's attempt to elicit parent's perspectives about a situation would also help to clarify the parents underlying concerns and demonstrate nurse's respect for parents.

- *"Patients' (parents') perspectives on what's distressing them can yield important clues about cause and effect, or 'attribution'* (Stein et al., 2011, p. 7).
- *Eliciting the patient's perspective consists of three components: assessing patient attribution, identifying requests for care, and exploring the impact of symptoms on the patient's well* being" (Stein et al., 2011, p. 7).

Content from "Four Habits Training and Evaluation Checklist"				
HABIT 2: Elicit the Parent's Perspective				
	Yes	*No*	*?*	*Notes/Comments*
Shows interest in exploring parent's understanding of the problem				
Shows interest in how the problem is affecting the parent				

Habit 2: Elicit the Parent's Perspective *(continued)* – applied to nurse-parent communication

Ask for the parent's ideas
- Ask for, listen to, and assess parent's point of view
- "What do you believe led us to this situation?"
- "What concerns you most about this situation?"

Elicit specific requests
- Determine parent's goal in dealing with the situation
- "What would be most helpful for me to do at this time?"

Explore the impact on the parent's life and their child's life
- Check context
- "How does this situation influence your satisfaction with your child's care?"

HABIT 3: Demonstrate Empathy – Parents accompanying their child during a hospitalization can be a very stressful experience. Many emotions can emerge for parents as they go through the process of looking for information about their child, getting answers to their questions, coping with bad news, and being involved in difficult health care decisions. Nurses may not be aware how emotions affect parents and parent's ability to take in new information. Nurses who purposefully take a few moments out of the

hectic process of care delivery to bring to the surface and welcome parent's emotions could be helpful in pediatric patient care.

- *"Feelings of vulnerability, anxiety, anger, and fear are common reactions to the uncertainties of new symptoms or the anticipation of undergoing tests or procedures. When clinicians recognize and acknowledge these emotions and help patients (parents) to identify and deal with them as part of their conversation, patients (parents) feel heard"(Stein et al., 2011, p. 11).*
- *"In order for empathy to be expressed effectively, at least three conditions need to be present: (1) Recognition that the clinician's role includes responding to patients' (parents') emotions, (2) The ability to discern opportunities for empathy across individual and cultural differences, and (3) A set of verbal and nonverbal skills for expressing empathy (Krasner et al., 2009; Stein et al., 2011, p. 11).*
- *"Empathic ability begins with sensitivity to nonverbal behavior (Stein et al., 2011, p. 12).*
- *"The final critical step in demonstrating empathy is conveying in words what has been understood from observing and listening to the patient (parent)" (Stein et al., 2011, p. 12).*
- *Defining attributes of empathy include seeing the world as others do, being non-judgmental, understanding another's feelings, and communicating the understanding (Wiseman, 1996).*

Content from "Four Habits Training and Evaluation Checklist"				
HABIT 3: Demonstrate Empathy				
	Yes	*No*	*?*	*Notes/Comments*
Encourages parent to express emotion and/or is openly receptive to parent's expression of emotion				
Makes comments indicating acceptance or validation of parent's feelings				
Makes an attempt to explore the parent's feelings by identifying or labeling them				
Displays nonverbal behavior that expresses interest, concern, and connection throughout the conversation				

Habit 3: Demonstrate Empathy *(continued)* – applied to nurse-parent communication

Be open to the parent's emotions

- Respond in a culturally appropriate manner to changes in body language and voice tone

Make an empathic statement

- Look for opportunities to use brief empathic comments; i.e., "You seem really worried, angry, upset . . ."

Convey empathy nonverbally

- Use a pause, touch, or facial expression showing concern and interest in the parent

HABIT 4: Invest in the End – Health care providers have many demands of their time making it impossible to have endless conversations. Ending a conversation in a manner that is satisfactory to both parties is difficult if one of the perspectives is missing or not taken into consideration. Careful planning on the nurse's part to include the parent's perspective could influence and possibly lead to positive outcomes and higher levels of parent satisfaction.

- *"The most significant challenge for busy clinicians in Habit 4 is to maintain focus on the patient (parent) given the competing demands" (Stein et al., 2011, p. 15).*
- *"Connecting patients (parents) to their illness narratives (concerns about their child) by using their own words creates a context in which diagnostic information and treatment recommendations are more likely to be understood and followed" (Stein et al., 2011, p. 15).*
- *"The final moments of the conversation include 3 skills: asking for additional questions, confirming next steps, and ending on a personal note" (Stein et al., 2011, p. 17).*

Content from "Four Habits Training and Evaluation Checklist"				
HABIT 4: Invest in the End				
	Yes	*No*	*?*	*Notes/Comments*
Frames relevant information in ways that reflect the parent's initial presentation of concerns				
Openly encourages and asks for additional questions from the parent				
Makes clear and specific plans for follow-up to the conversation				

Habit 4: Invest in the End – additional information for nurse-parent communication

Involve parent in making decisions

- Discuss remedy goals to ensure mutual understanding and agreement
- Explore barriers: "What do you think would help overcome or avoid problems like this from happening in the future?"

Completing the visit/conversation

- Summarize conversation and review next steps

- Verify parent's comprehension by asking parent to repeat plan
- Ask "What questions to you have about what we discussed today?"
- Close conversation in a positive way: i.e., "It's been nice talking with you. Thank you for your time."

Brief review, questions, discussion, and wrap-up: *(refer to the laminated card provided)*

Habit 1: Beginning = Names and introductions – *DON'T forget to introduce & use names*

Habit 2: Parent's perspective = Ask and bring forth – *DON'T assume or tell*

Habit 3: Empathy = Accept and embrace emotions – *DON'T avoid emotions*

Habit 4: End = Negotiate next steps – close positively – *DON'T state next steps*

Four Habits Training and Evaluation Checklist

Adapted from the Four Habits Model Coding Scheme (Krupat et al., 2006)

Please mark the role you played for nurse-parent communication #1: __ nurse __ observer

	Yes	*No*	*?*	*Notes/Comments*
Habit 1: Invest in the Beginning				
Greets parent in a personal and warm manner				
Attempts to identify problem using open-ended questions				
Habit 2: Elicit the Parent's Perspective				
Shows interest in exploring parent's understanding of the problem				
Shows interest in how the problem is affecting the parent				
Habit 3: Demonstrate Empathy				
Encourages parent to express emotion and/or is openly receptive to parent's expression of emotion				
Makes comments indicating acceptance or validation of parent's feelings				
Makes an attempt to explore the parent's feelings by identifying or labeling them				
Displays nonverbal behavior that expresses interest, concern, and connection throughout the conversation				
Habit 4: Invest in the End				
Frames relevant information in ways that reflect the parent's initial presentation of concerns				
Openly encourages and asks for additional questions from the parent				
Makes clear and specific plans for follow-up to the conversation				

Additional notes/comments: _____

_____

Four Habits Training and Evaluation Exemplars
Adapted from the Four Habits Model Coding Scheme (Krupat et al., 2006)

Habit 1: Invest in the Beginning
Greets parent in a personal and warm manner - Nurse's expected or appropriate response: Donna is greeted in manner that is personal and warm [e.g., nurse asks Donna how she likes to be addressed, uses Donna's name]. - Nurse's neither completely expected nor entirely appropriate response: Donna is greeted in manner that recognizes her, but without great warmth or personalization. - Nurse's unexpected or inappropriate response: Greeting of Donna is cursory, impersonal, or nonexistent. Nurse tries to identify the problem(s) using primarily closed-ended questions (staccato style).
Attempts to identify problem using open-ended questions - Nurse's expected or appropriate response: The nurse tries to identify the problem(s) using primarily open-ended questions (asks questions in a way that allows Donna to tell her own story with minimum of interruptions or closed ended questions). - Nurse's neither completely expected nor entirely appropriate response: The nurse tries to identify the problem(s) using a combination of open and closed ended questions (possibly begins with open-ended but quickly reverts to closed ended). - Nurse's unexpected or inappropriate response: Greeting of Donna is cursory, impersonal, or nonexistent. Nurse tries to identify the problem(s) using primarily closed-ended questions (staccato style).
Habit 2: Elicit the Parent's Perspective
Shows interest in exploring parent's understanding of the problem - Nurse's expected or appropriate response: Nurse shows great interest in exploring Donna's understanding of the problem (e.g., asks Donna what the problem/situation means to her). - Nurse's neither completely expected nor entirely appropriate response: Nurse shows brief or superficial interest in understanding Donna's understanding of the problem. - Nurse's unexpected or inappropriate response: Nurse makes no attempt/shows no interest in understanding Donna's perspective.
Shows interest in how the problem is affecting the parent - Nurse's expected or appropriate response: Nurse attempts to determine in detail/shows great interest in how the problem is affecting Donna. - Nurse's neither completely expected nor entirely appropriate response: Nurse attempts to determine briefly/shows only some interest in how the problem is affecting Donna. - Nurse's unexpected or inappropriate response: Nurse makes no attempt to

determine/shows no interest in how the problem is affecting Donna.

Habit 3: Demonstrate Empathy
Encourages parent to express emotion and/or is openly receptive to parent's expression of emotion - Nurse's <u>expected or appropriate</u> response: Nurse openly encourage/is receptive to the expression of emotion (e.g., through use of continuers or appropriate pauses (signals verbally or nonverbally that it is okay to express feelings). - Nurse's <u>neither completely expected nor entirely appropriate</u> response: Nurse shows relatively little interest or encouragement for Donna's expression of emotion; or allows emotions to be shown but actively or subtly encourages Donna to move on. - Nurse's <u>unexpected or inappropriate</u> response: Nurse shows no interest in Donna's emotional state and/or discourages or cuts off the expression of emotion by Donna (signals verbally or nonverbally that it is not okay to express emotions).
Makes comments indicating acceptance or validation of parent's feelings - Nurse's <u>expected or appropriate</u> response: Nurse makes comments clearly indicating acceptance/validation of Donna's feelings (e.g., I'd feel the same way . . . I can see how that would worry you . . .). - Nurse's <u>neither completely expected nor entirely appropriate</u> response: Nurse briefly acknowledges Donna's feelings but makes no effort to indicate acceptance/validation. - Nurse's <u>unexpected or inappropriate</u> response: Nurse makes no attempt to respond to/validate Donna's feelings, or possibly belittles or challenges them (e.g., It's ridiculous to be so concerned about . . .).
Makes an attempt to explore the parent's feelings by identifying or labeling them - Nurse's <u>expected or appropriate</u> response: Clinician makes clear attempt to explore parent's feelings by identifying or labeling them (e.g., So how does that make you feel? It seems to me that you are feeling quite anxious about . . .). - Nurse's <u>neither completely expected nor entirely appropriate</u> response: Nurse makes brief reference to Donna's feelings, but does little to explore them by identification or labeling. - Nurse's <u>unexpected or inappropriate</u> response: Nurse makes no attempt to identify Donna's feelings.
Displays nonverbal behavior that expresses interest, concern, and connection throughout the conversation - Nurse's <u>expected or appropriate</u> response: Clinician displays nonverbal behaviors that express great interest, concern, and connection (e.g., eye contact, tone of voice, and body orientation) throughout the conversation. - Nurse's <u>neither completely expected nor entirely appropriate</u> response: Nurse's

nonverbal behavior shows neither great interest nor disinterest (or behaviors over course of conversation are inconsistent).
- Nurse's unexpected or inappropriate response: Nurse's nonverbal behavior displays lack of interest and/or concern and/or connection (e.g., little or no eye contact, body orientation or use of space inappropriate, bored voice).

Habit 4: Invest in the End
Frames relevant information in ways that reflect the parent's initial presentation of concerns - Nurse's expected or appropriate response: Nurse frames conversation in ways that reflect parent's initial presentation of concerns. - Nurse's neither completely expected nor entirely appropriate response: Nurse makes cursory attempt to frame conversation in terms of Donna's concerns. - Nurse's unexpected or inappropriate response: Nurse frames conversation in terms that fit nurse's frame of reference rather than incorporating Donna's.
Openly encourages and asks for additional questions from the parent - Nurse's expected or appropriate response: Nurse openly encourages and asks for additional questions from Donna (and responds to them in at least some detail). - Nurse's neither completely expected nor entirely appropriate response: Nurse allows for additional questions from Donna, but does not encourage question asking nor respond to them in much detail. - Nurse's unexpected or inappropriate response: Nurse makes no attempt to solicit additional questions from Donna or largely ignores them if made unsolicited.
Makes clear and specific plans for follow-up to the conversation - Nurse's expected or appropriate response: Nurse makes clear and specific plans for follow-up to the conversation. - Nurse's neither completely expected nor entirely appropriate response: Nurse makes references to follow-up, but does not make specific plans. - Nurse's unexpected or inappropriate response: Nurse makes no reference to follow-up plans.

<u>Second 20-minutes:</u> Simulated Nurse-Parent Communication using Four Habits

(sessions will be digitally audio and video recorded as noted and stated in consent form)

Activities and assignments:

- One volunteer to be the nurse for first scenario and another for second scenario (same scenario)
- All of the others are observers
- Parent in the scenario is a standardized parent
- Following two rounds of the scenario with two different nurses, all nurses and observers take a few minutes to complete the two Four Habits Training and Evaluation Checklists (one for each of the two scenario sessions)

Nurse-Parent Communication Scenario – Donna and her son Daniel

Background

Daniel is a five-year old child who has a history of a congenital heart defect. He is currently in the medical unit after a lengthy stay in the pediatric intensive care unit (PICU) following heart surgery. Daniel's congenital heart problems and subsequent surgeries have led to respiratory problems involving infections, extensive antibiotic treatment, and artificial respiration. Daniel's respiratory issues recently led to a trip to the emergency room, a long stay in the PICU complicated by a harmful medication mistake, and a very slow recovery on the medical floor.

Daniel's mother, Donna, has been at his bedside the majority of time he has been in the hospital. Daniel's father, Joe, has been at his bedside in the past but is unable now because he has used up his paid time off. Donna is an active participant in Daniel's care providing specific information about him and assisting with his basic care needs including bathing, pain assessment, and administration of routine oral medications. Additionally, Donna participates in all other medication administration by carefully verifying IV medications, administration times, and medication dosages. Donna loyally serves as her son's advocate attentively observing and monitoring Daniel's care. Most of the nurses have had positive interactions with his parents.

Current Issue

Today, Daniel's IV antibiotic initiated fifteen minutes ago when his mother was not as his bedside, was the incorrect medication. You are the newly licensed nurse assigned to Daniel for the first time who inadvertently administered the incorrect medication. It is now 7:15 am and Donna has returned to Daniel's bedside. You have disconnected the IV and turn to Donna to inform her that Daniel received the incorrect antibiotic caused by a physician's incorrect order.

<u>Third (last) 20-minutes:</u> Debrief, Wrap-up, Questions-Answers, and Review

Debriefing will take place following the scenario involving a discussion of the process, outcome, application of the scenario in clinical practice, and review of objectives leading to participants' processing information and critically thinking (Jeffries, 2005). The PI will lead a twenty-minute debriefing session with the nurse playing the "nurse" role in the scenario, the other nurse observers, and the standardized parent. The debriefing sessions begins with the simulation facilitator asking the "nurse" about their experience, going over the "nurse's" Four Habits Training and Evaluation Checklists, followed by a review of the observers' checklists, an open question and answer session, and concluded with a review of the training session goals and objectives facilitated by the PI.

Debrief outline:

1. What was the nurse-parent communication scenario experience like for the nurses?
2. What was the nurse-parent communication scenario experience like for the observers?
3. Review nurse's and observers completed Four Habits Training and Evaluation Checklists
4. What was the nurse-parent communication scenario experience like for the standardized parent?
5. How can this material be applied in the clinical setting?
    a. Describe a few scenarios in the hospital that you have been a part of where parent's emotions have been shared where the Four Habits might be helpful
    b. Do you see yourself using the Four Habits in clinical practice? If so, how will you use them when communicating with parents in clinical practice?
6. The Four Habits communication training session learning objectives review:
    a. Identify and describe the Four Habits and their use in nurse-parent communication
    b. Describe and discuss process of using the Four Habits in nurse-parent communication
    c. Apply and evaluate use of the Four Habits in a simulated nurse-parent communication

APPENDIX D: LAMINATED FOUR HABITS CARD FOR NURSES/PARTICIPANTS

Front of card

Four Habits: Nurse-Parent Communication

HABIT 1: INVEST IN THE BEGINNING

Introduce self to those in the room using names

HABIT 2: GET PARENT'S PERSPECTIVE

Elicit and assess parent's point of view

HABIT 3: DEMONSTRATE EMPATHY

Identify and be open to parent's emotions

HABIT 4: INVEST IN THE END

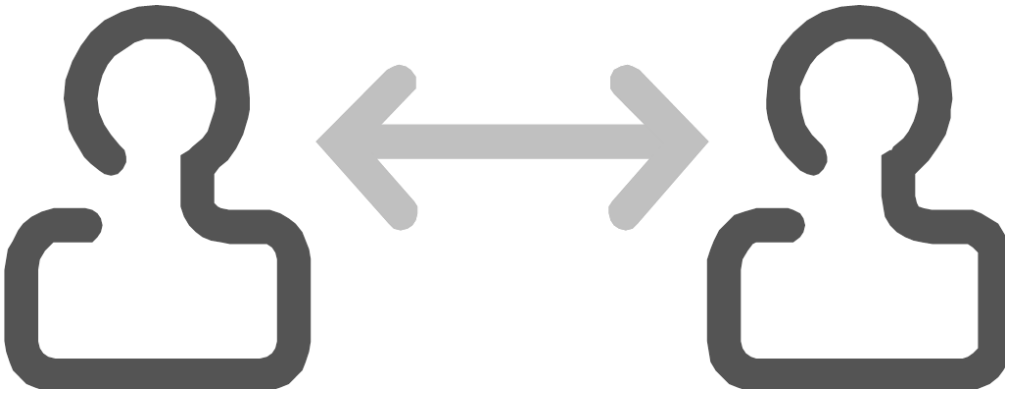
Collaborate on next steps and close in a positive way

Back of card

Card content by Mark J. Fisher, MS, RN

For more information about the Four Habits Model, refer to: Stein, T., Krupat, E., & Frankel, R. M. (2011). *Talking with Patients Using the Four Habits Model* Kaiser Permanente. Oakland, California: Madison Street Press.
http://www.madisonstreetpress.com/monograph.shtml

A Brief Intervention to Improve Emotion-Focused Communication between Newly Licensed Pediatric Nurses and Parents



Standardized Parent Training Manual

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Cell: (number provided)

Study date: November 18, 2011

The University of Oklahoma Health Sciences Center IRB approved study #16053
Indiana University IRB approved study #1109006673

A Brief Intervention to Improve Emotion-Focused Communication between Newly Licensed Pediatric Nurses and Parents

Abstract

An estimated 2,000,000 children were admitted to hospitals in the United States over one year with an average length of stay of four days, according to a recent National Center for Health Statistics report. Parents accompanying their children during hospitalization endure their own stressful and often emotion-filled experience. Ineffectively handled or ignored emotions expressed by parents create barriers in pediatric patient care. Nurses are in a unique position to capitalize on partnering opportunities with parents because of their frequent contact and communication with parents. Communication is likely a part of all professional nursing education programs, however, how and when nurses learn how to communicate with parents during emotion-focused conversations is not clear. Communication training programs for nurses and other practicing professionals typically require hours, days, or weeks to complete. Brief, Innovative, and creative communication training programs could be useful in preparing early career nurses for emotion-focused conversations. Yet, these types of educational opportunities are rare or nonexistent. **The purpose of this study is to evaluate the impact of a brief (one-hour) innovative communication training intervention for early career pediatric nurses intended to improve their preparation for emotion-focused conversations with parents.** This quasi-experimental study will employ a group-by-trials repeated measures ANOVA design. Both quantitative and qualitative approaches for data collection will be used to evaluate outcomes. It is hypothesized nurses in the treatment group will improve their sense of preparation for emotion-focused conversations with parents. Additionally, nurses are expected to apply content learned and experience gained in the clinical setting.

The material from an initial post-conference project described in an abbreviated form of a manuscript involved sixty-four (64) undergraduate nursing students and two parents during fall 2009 (Fisher et al., 2012). *(Note: The manuscript was published after this manual was created; therefore, the abbreviated form of the manuscript is no longer included in this training manual.)* These initial one-hour post-conference sessions led to an expanded set of parent-nurse communication training sessions involving over 300 undergraduate students and ten parents (including one husband and wife pair) during fall 2010 and fall 2011. All of these nursing student sessions and parent-led sessions significantly influenced and informed this current dissertation research study.

Additional influence for this project comes from *Josie's Story* which provides is an account of a parent's personal struggle with a strained if not broken health care system. Sorrels' story informs and influences my research, education, and service. She provides a meaningful and valued perspective of a parent interested in having her voice heard, among a group of providers wanting to do and act – it is their profession. Speaking at the national conference of the Institute for Healthcare Improvement (IHI) in October 2002, Sorrel King described the series of errors that led to her daughter's death:

[H]er central line had been taken out. I began noticing that every time she saw a drink she would scream for it, and I thought this was strange. I was told not to let her drink. While a nurse and I gave her a bath, she sucked furiously on a washcloth. As I put her to bed, I noticed that her eyes were rolling back in her head. Although I asked the nurse to call the doctor, she reassured me that oftentimes children did this and her vitals were fine. I told her Josie had never done this and perhaps another nurse could look at her. After yet another reassurance from another nurse that everything was fine, I was told that it was OK for me to sleep at home. . . . [But the next morning] she was not fine. Josie's medical team arrived and administered two shots of Narcan [naloxone]. I asked if she could have something to drink. The request was approved, and Josie gulped down nearly a liter of juice.

Verbal orders were issued for there to be no narcotics given. As I sat with Josie, I noticed that the nurse on morning duty was acting very strangely. She seemed nervous, overly demonstrative, and in a hurry. . . . I expressed my concern to one of the doctors, and he agreed that she was acting a bit odd. Meanwhile, Josie started perking up. She was more alert and had kept all liquids down. I was still scared and asked her doctors to please stay close by. At 1:00 [pm] the nurse walked over with a syringe of methadone. Alarmed, I told her that there had been an order for no narcotics. She said the orders had been changed and administered the drug.

Josie's heart stopped as I was rubbing her feet. Her eyes were fixed, and I screamed for help. I stood helpless as a crowd of doctors and nurses came running into her room. I was ushered into a small room with a chaplain. The next time I saw Josie she had been moved back up to the [pediatric ICU]. Doctors and nurses were standing around her bed. No one seemed to want to look at me. . . . [Two days later] Josie was taken off of life support. She died in our arms on a snowy night in what's considered to be one of the best hospitals in the world. . . . Josie's death was not the fault of one doctor, or one nurse, or one misplaced decimal point. It was the result of a total breakdown in the system.

Sources for content and details for *Josie's Story*: (Greenhouse, Kuzminsky, Martin, & Merryman, 2006, pp. 63-64; King, 2007; 2009, pp. 42-54)

Nurses: Novice to Expert – theoretical background/support

- As many as ten percent of the nurses in hospitals where acute care is provided are new graduates (Nursing Executive Center, 2007)
- Newly licensed nurses entering the field as advanced beginners must develop the skills and acquire the tools to adapt and change with their patients and families needs (Benner et al., 2009)
- Newly licensed nurses' limited experience and knowledge are influenced by their time and attention focused on knowledge acquisition, orientation to tasks, and technical skill development (Benner et al., 2009; Linder, 2009)

- Being familiar with and emotionally attuned to a situation facilitates judgment helping early career nurses see and interpret the meaningful aspects of a particular situation (Benner et al., 2009)

Unfortunately, newly licensed nurses' concentration on tasks and technical skills, may make dealing with parents' emotions difficult, and may produce anxiety limiting nurse's confidence in being prepared for emotion-focused conversations with parents.

- Anxiety about personal insufficiencies in facing clinical demands can create distance between nurses and parents making emotion-focused conversations difficult (Benner et al., 2009)
- Anxiety from first-time encounters can disable new nurses, however, their anxiety can also make them more vigilant in their care (Benner et al., 2009)
- The more knowledgeable or expert a nurse is depends on the amount of information she/she can process unconsciously and automatically (Benner, 1984; Benner et al., 2009; Benner et al., 1996)

By providing newly licensed nurses with a set of **habits** useful in emotion-focused conversations, nurses could reduce their anxiety and increase their ability to process more emotion-focused information instinctively.

Nurse-Parent Communication Scenario – Donna and her son Daniel

Background

Daniel is a five-year old child who has a history of a congenital heart defect. He is currently in the medical unit after a lengthy stay in the pediatric intensive care unit (PICU) following heart surgery. Daniel's congenital heart problems and subsequent surgeries have led to respiratory problems involving infections, extensive antibiotic treatment, and artificial respiration. Daniel's respiratory issues recently led to a trip to the emergency room, a long stay in the PICU complicated by a harmful medication mistake, and a very slow recovery on the medical floor.

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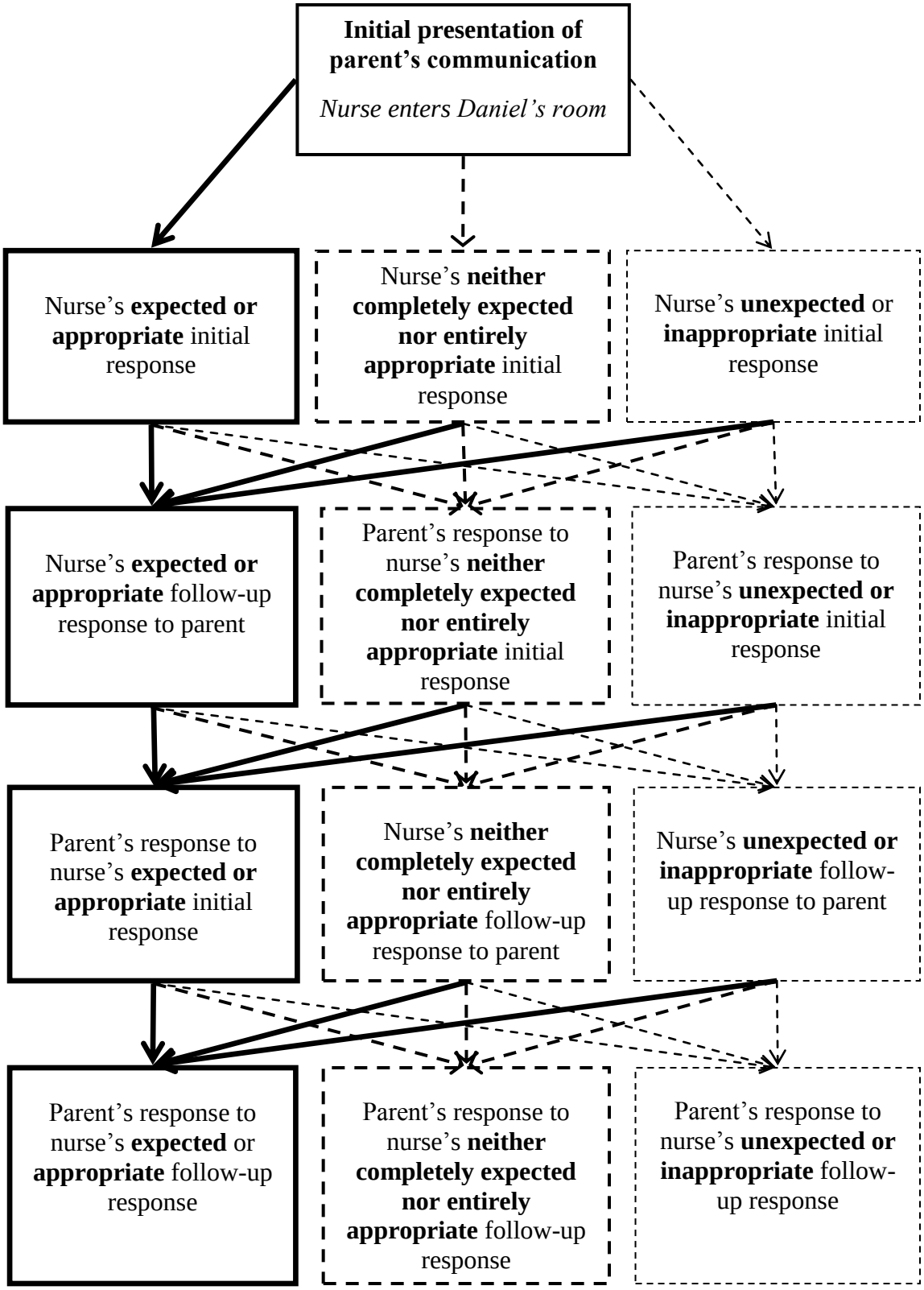
Initial presentation of parent's communication
Nurse enters Daniel's room
Nurse's **expected or appropriate** initial response
Nurse's **neither completely expected nor entirely appropriate** initial response
Nurse's **unexpected** or **inappropriate** initial response
Nurse's **expected or appropriate** follow-up response to parent
Parent's response to nurse's **neither completely expected nor entirely appropriate** initial response
Parent's response to nurse's **unexpected or inappropriate** initial response
Parent's response to nurse's **expected or appropriate** initial response
Nurse's **neither completely expected nor entirely appropriate** follow-up response to parent
Nurse's **unexpected or inappropriate** follow-up response to parent
Parent's response to nurse's **expected** or **appropriate** follow-up response
Parent's response to nurse's **neither completely expected nor entirely appropriate** follow-up response
Parent's response to nurse's **unexpected or inappropriate** follow-up response

Nurse-Parent communication basic script and general outline

Initial presentation of parent's communication

Donna appears to have an angry look on her face as she looks at you and begins making demands through a series of rapid-fire questions directly at you: "What do you mean he got the wrong medication? What is this going to do to him? How did you let this happen? What happened?"

Some of Donna's potential emotions emerging from the situation: anger, frustration, disappointment (second medication error), sense of responsibility (Donna not being at Daniel's bedside when med administered), loss of trust in health care providers (second error – last one was harmful), and others.

Expected or appropriate – *(Main goal for nurse-parent communication using the Four Habits)*

Nurse: "Hello, my name is Jennifer. I am the nurse that has been assigned to care for Daniel and I will be working with you today. Do you prefer to be called Mrs. Smith or Donna? *(Wait for response)* The medication was stopped quickly, Daniel is not allergic to the medication, so this should not cause any problems for Daniel. Unfortunately, the antibiotic Daniel started to receive was one that was incorrectly ordered by the non-attending or resident physician. You look like you are very angry and upset . . . tell me about the concerns. "

Parent: "Hello Jennifer, please call me Donna. This is the second time you all have messed up with Daniel's medication! The last time is seemed like Daniel might not even make it through. I am so frustrated with the mistakes and I feel like I need to be at Daniel's bedside 24 hours a day 7 days a week if he is to get the care he needs and deserves. What is going on that this keeps happening?"

Nurse: "Tell me more about your concerns. I have the time and this is important. I see you are shaking and appear very angry." *(Silence. Wait for Donna's response.) (Nonverbal behavior: nurse is sitting at Daniel's bedside close to Donna, looking eye-to-eye with Donna, and allowing silence to be filled in by Donna as needed; creating an atmosphere of calm with the attention on Donna, her verbalized concerns, and her nonverbal communication)*

Parent: "I just want Daniel to get better. I am doing everything that I can to make sure that happens but I leave the room for a few minutes and this happens. I was so worried about Daniel making through the last medication error and now this happens. Please let me know if you can have the doctor come back to talk with me about what happened and how it will affect Daniel's recovery. I would also like to know the plan to make sure this type of thing does not happen again. I appreciate your help and your time to listen to me go on about Daniel and all of my concerns. Daniel is my life. He means everything to me."

Nurse's concluding comments: "We want Daniel to get better as well. In addition to that, we want to be sure your concerns, issues, and comments are heard and understood. I believe even if you were here when the medication was administered you might not have been able to catch the error. It is clear that your previous experience with the major medication mistake made a lasting negative impression on you. I will look into how today's mistake occurred and I will arrange to have the doctor who wrote the order come back to talk with you. We will develop a plan together in how events such as these can be avoided in the future. I talked with the doctor and he said we should be able to meet with him in about an hour. He is making rounds on his other patients and wanted you to know he will help us get to the bottom of the problem and discuss any and all of your concerns. We have an understanding of how important Daniel is to you and we want to do everything we can to help him get better so he can go home with you soon."

Neither completely expected nor entirely appropriate

Nurse: "Hello Ms. Smith. I will be taking care of Daniel today. Daniel did not get much of the wrong medication and it was stopped quickly. I will get the new ordered medication and administer it when it comes to the unit. Do you have concerns? Is there anything else you want to know about the incident? Do you need anything else right now?"

Parent: "Yes I have concerns! Yes, I have some questions! What happened? Why was there an error in the medication order? This is the second error in Daniel's care, what are you all doing wrong?!"

Nurse: "I see you have some concerns. I can see this is upsetting you. We are doing what we can to get the right medication up here to the unit and we will administer it when it gets here. *(Nurse is constantly moving toward the door and appears to be interested occasionally looking at Donna at times and then looking at the clock appearing to be ready to move on to caring for her other patients.)*

Parent: "Can you tell me how this happened? Can you tell me how this will be avoided in the future? Can you tell me what this might do to Daniel and how it might interfere with his recovery? Can you tell me this will not end up as bad as it did with the last medication mistake?"

Nurse's concluding comments: "The doctor wrote the wrong prescription. It should not affect Daniel's recovery. This medication issue will not end up like the last error because it is not as bad of an error. I can talk with you some more later this morning, after I take care of my other patients."

Unexpected or inappropriate

Nurse: "I'm the nurse assigned to this room. It was the wrong medication. I will have the correct one soon and I will administer it when it gets here. It is not a big deal. Do you want anything now? I need to go and see my other patients."

Parent: "What?! It's a big deal to me and it's a big deal to Daniel! What are you all doing to my son?! This is the second mistake you have made. The last one almost killed Daniel! Tell the physician who wrote the wrong order and that I want to see him and his attending physician right now. I want some answers!"

Nurse: "I need to complete my assessment on my other patients and administer their medications. It's not that big of a deal anyway. I will contact the doctor when I get a chance or break in my busy schedule." *(Nurse says this as she walks out of the room to make her rounds with her other patients).*

Parent: "I want to talk to the nurse in charge! Get the doctor in here now!"

Nurse's concluding comments: "When I finish my other patient's morning assessments and medications I will get the charge nurse and doctor for you."

Nurse's initial response in the context of the Four Habits

Habit 1: Invest in the Beginning

Frankel & Stein, 1999; Krupat, Frankel, Stein, & Irish, 2006; Stein, Frankel, & Krupat, 2005; Stein, Krupat, & Frankel, 2011

Nurse's <u>expected or appropriate</u> initial response:

- "Hello, my name is Jennifer. I am the nurse that has been assigned to care for Daniel and I will be working with you today. Do you prefer to be called Mrs. Smith or Donna? *(wait for response)* The medication was stopped quickly, Daniel is not allergic to the medication, so this should not cause any problems for Daniel. Unfortunately, the antibiotic Daniel started to receive was incorrectly ordered by the non-attending or resident physician. You look like you are very angry and upset . . . tell me about the concerns. "

Habit 1: Donna is greeted in manner that is personal and warm [e.g., nurse asks Donna how she likes to be addressed, uses Donna's name]. The nurse tries to identify the problem(s) using primarily open-ended questions (asks questions in a way that allows Donna to tell her own story with minimum of interruptions or closed ended questions)

Nurse's <u>neither completely expected nor entirely appropriate</u> initial response:

- "Hello Ms. Smith. I will be taking care of Daniel today. Daniel did not get much of the wrong medication and it was stopped quickly. I will get the new ordered medication and administer it when it comes to the unit. Do you have concerns? Is there anything else you want to know about the incident? Do you need anything else right now?"

Habit 1: Donna is greeted in manner that recognizes her, but without great warmth or personalization. The nurse tries to identify the problem(s) using a combination of open and closed ended questions (possibly begins with open-ended but quickly reverts to closed ended)

Nurse's <u>unexpected or inappropriate</u> initial response:

- "I'm the nurse assigned to this room. It was the wrong medication. I will have the correct one soon and I will administer it when it gets here. It is not a big deal. Do you want anything now? I need to go and see my other patients."

Habit 1: Greeting of Donna is cursory, impersonal, or nonexistent. Nurse tries to identify the problem(s) using primarily closed-ended questions (staccato style)

Parent's response to nurse's initial response

Parent's response to nurse's <u>expected or appropriate</u> initial response:

- "Hello Jennifer, please call me Donna. This is the second time you all have messed up with Daniel's medication! The last time is seemed like Daniel might not even make it through. I am so frustrated with the mistakes and I feel like I need to be at Daniel's bedside 24 hours a day 7 days a week if he is to get the care he needs and deserves. What is going on that this keeps happening?"

Parent's response to nurse's <u>neither completely expected nor entirely appropriate</u> initial response:

- "Yes, I have concerns! Yes I have some questions! What happened? Why was there an error in the medication order? This is the second error in Daniel's care, what are you all doing wrong?!"

Parent's response to nurse's <u>unexpected or inappropriate</u> initial response:

- "What?! It's a big deal to me and it's a big deal to Daniel! What are you all doing to my son?! This is the second mistake you have made. The last one almost killed Daniel! Tell the physician who wrote the wrong order and that I want to see him and his attending physician right now. I want some answers!"

Nurse's follow-up response to parent in the context of the Four Habits
Habit 2: Elicit the Parent's Perspective and Habit 3: Demonstrate Empathy

Nurse's <u>expected or appropriate</u> follow-up response to parent:

- "Tell me more about your concerns. I have the time and this is important. I see you are shaking and appear very angry." *(Silence. Wait for Donna's response.) (Nonverbal behavior: nurse is sitting at Daniel's bedside close to Donna, looking eye-to-eye with Donna, and allowing silence to be filled in by Donna as needed; creating an atmosphere of calm with the attention on Donna, her verbalized concerns, and her nonverbal communication.)*

<u>Habit 2:</u> Nurse shows great interest in exploring Donna's understanding of the problem (e.g., asks Donna what the problem/situation means to her). Nurse attempts to determine in detail/shows great interest in how the problem is affecting Donna.
<u>Habit 3:</u> Nurse openly encourage/is receptive to the expression of emotion (e.g., through use of continuers or appropriate pauses (signals verbally or nonverbally that it is okay to express feelings). Nurse makes comments clearly indicating acceptance/validation of Donna's feelings (e.g., I'd feel the same way . . . I can see how that would worry you . . .). Clinician makes clear attempt to explore parent's feelings by identifying or labeling them (e.g., So how does that make you feel? It seems to me that you are feeling quite anxious about . . .). Clinician displays nonverbal behaviors that express great interest, concern, and connection (e.g., eye contact, tone of voice, and body orientation) throughout the conversation.

Nurse's <u>neither completely expected nor entirely appropriate</u> follow-up response to parent:

- "I see you have some concerns. I can see this is upsetting you. We are doing what we can to get the right medication up here to the unit and we will administer it when it gets here. *(Nurse is constantly moving toward the door and appears to be interested occasionally looking at Donna at times and then looking at the clock appearing to be ready to move on to caring for her other patients.)*

<u>Habit 2:</u> Nurse shows brief or superficial interest in understanding Donna's understanding of the problem. Nurse attempts to determine briefly/shows only some interest in how the problem is affecting Donna.
<u>Habit 3:</u> Nurse shows relatively little interest or encouragement for Donna's expression of emotion; or allows emotions to be shown but actively or subtly encourages Donna to move on. Nurse briefly acknowledges Donna's feelings but makes no effort to indicate acceptance/validation. Nurse makes brief reference to Donna's feelings, but does little to explore them by identification or labeling. Nurse's nonverbal behavior shows neither great interest nor disinterest (or behaviors over course of conversation are inconsistent).

Nurse's <u>unexpected or inappropriate</u> follow-up response to parent:

- "I need to complete my assessment on my other patients and administer their medications. It's not that big of a deal anyway. I will contact the doctor when I get a chance or break in my busy schedule." *(Nurse says this as she walks out of the room to make her rounds with her other patients).*

<u>Habit 2:</u> Nurse makes no attempt/shows no interest in understanding Donna's perspective. Nurse makes no attempt to determine/shows no interest in how the problem is affecting Donna.
<u>Habit 3:</u> Nurse shows no interest in Donna's emotional state and/or discourages or cuts off the expression of emotion by Donna (signals verbally or nonverbally that it is not okay to express emotions). Nurse makes no attempt to respond to/validate Donna's feelings, or possibly belittles or challenges them (e.g., It's ridiculous to be so concerned about . . .). Nurse makes no attempt to identify Donna's feelings.

Nurse's nonverbal behavior displays lack of interest and/or concern and/or connection (e.g., little or no eye contact, body orientation or use of space inappropriate, bored voice).

Parent's response to nurse's follow-up response

Parent's response to nurse's <u>expected or appropriate</u> follow-up response:

- "I just want Daniel to get better. I am doing everything that I can to make sure that happens but I leave the room for a few minutes and this happens. I was so worried about Daniel making through the last medication error and now this happens. Please let me know if you can have the doctor come back to talk with me about what happened and how it will affect Daniel's recovery. I would also like to know the plan to make sure this type of thing does not happen again. I appreciate your help and your time to listen to me go on about Daniel and all of my concerns. Daniel is my life. He means everything to me."

Parent's response to nurse's <u>neither completely expected nor entirely appropriate</u> follow-up response:

- "Can you tell me how this happened? Can you tell me how this will be avoided in the future? Can you tell me what this might do to Daniel and how it might interfere with his recovery? Can you tell me this will not end up as bad as it did with the last mistake?"

Parent's response to nurse's <u>unexpected or inappropriate</u> follow-up response:

- "I want to talk to the nurse in charge! Get the doctor in here now!"

Nurse's continued conversation with parent in the context of the Four Habits
Habit 4: Invest in the End

Nurse's <u>expected or appropriate</u> concluding response to parent:

- "We want Daniel to get better as well. In addition to that, we want to be sure your concerns, issues, and comments are heard and understood. I believe even if you were here when the medication was administered you might not have been able to catch the error. It is clear that your previous experience with the major medication mistake made a lasting negative impression on you. I will look into how today's mistake occurred and I will make arrangements to have the doctor who wrote the order come back to talk with you. We will develop a plan together in how events such as these can be avoided in the future. I talked with the doctor and he said we should be able to meet with him in about an hour. He is making rounds on his other patients and wanted you to know he will help us get to the bottom of the problem and discuss any and all of your concerns. We have an understanding of how important Daniel is to you and we want to do everything we can to help him get better so he can go home with you soon."

Habit 4: Nurse frames conversation in ways that reflect parent's initial presentation of concerns. Nurse openly encourages and asks for additional questions from Donna (and responds to them in at least some detail). Nurse makes clear and specific plans for follow-up to the conversation.

Nurse's <u>neither completely expected nor entirely appropriate</u> concluding response to parent:

- "The doctor wrote the wrong prescription. It should not affect Daniel's recovery. This medication issue will not end up like the last error because it is not as bad of an error. I can talk with you some more later this morning, after I take care of my other patients."

Habit 4: Nurse makes cursory attempt to frame conversation in terms of Donna's concerns. Nurse allows for additional questions from Donna, but does not encourage question asking nor respond to them in much detail. Nurse makes references to follow-up, but does not make specific plans.

Nurse's <u>unexpected or inappropriate</u> concluding response to parent:

"When I finish my other patient's morning assessments and medications I will get the charge nurse and doctor for you."

Habit 4: Nurse frames conversation in terms that fit nurse's frame of reference rather than incorporating Donna's. Nurse makes no attempt to solicit additional questions from Donna or largely ignores them if made unsolicited. Nurse makes no reference to follow-up plans.

APPENDIX F: PERCS PRE-QUESTIONNAIRE – ADAPTED VERSION

(converted into an electronic version for this study)

Participant #: _____ Today's date: _____

Email address:

_____

Mailing address:

_____

street address *city* *zip code*

Contact telephone #: (_____) _____

1. Registered Nursing (RN) experience in months: *(# months with RN license)* _____
2. Pediatric nursing experience in months: *(# months working with children as an RN)* _____
3. Nursing education: *(please mark all that apply)*
   a. ___ Associate Degree in Nursing
   b. ___ Bachelor of Science – initial or first degree
   c. ___ Bachelor of Science – accelerated (second degree)
   d. ___ Bachelor of Science – second degree (non-nursing/non-accelerated)
   e. ___ Currently enrolled in degree program: *(if marked, please describe program)* _____
   f. ___ Other; please describe: _____
      _____
4. Age in years: _____
5. Gender *(please circle one)* Female Male
6. Ethnicity *(please mark one)*
   ___ Hispanic
   ___ African American
   ___ Native American
   ___ Other *(please specify)*
   ___ Caucasian, not of Hispanic origin
   ___ Asian
   ___ Two or more ethnicities
   _____

7. What are your expectations about the Nurse-Parent Emotion-Focused Communication training program? *(please mark those that apply)*
   ___ Learn how to communicate with parents better (i.e. tips and suggestions)
   ___ List the do's and don'ts of communicating with parents
   ___ Identify the correct words to use when communicating with parents
   ___ Increase awareness of parents' expectations during nurse-parent communication
   ___ Practice appropriate responses when communicating with parents
   ___ Learn more about how nurses can help parents during an emotional time

___ Identify ways to incorporate parents more effectively in their child's patient care
___ Recognize what nurses can do to more effectively practice family-centered care
___ Other: *(please describe)* _____
_____

We would appreciate your responses to the following questions in an effort to better understand participants' communication training and to evaluate the study. The questionnaire takes about ten minutes to complete. Thank you very much.

8. Have you had any form of communication training that you believe has prepared you for emotion-focused conversations with parents? *(For this study: emotion-focused conversations with parents are parent-provider exchanges where parents verbally or non-verbally express their feelings to a provider and the provider either does or does not address the parent's feelings.)*

YES ___ NO ___ If yes, please describe: _____

_____

_____

_____

_____

9. Have you had any form of AIDET communication training? YES ___ NO ___
If yes, how long ago? _____ months and _____ weeks. If yes, please identify what AIDET is stands for:

A) _____

I) _____

D) _____

E) _____

T) _____

10. Have you had any form of Four Habits communication training? YES ___ NO ___
If yes, how long ago? _____ months and _____ weeks. If yes, please list the Four Habits:

1) _____

2) _____

3) _____

4) _____

11. In general, how prepared do you consider yourself to be in having emotion-focused conversations with parents? *(please circle one)*

1	2	3	4	5
Not at all Prepared	A little prepared	Somewhat prepared	Quite prepared	Very prepared

12. How would you assess your own communication skills in having emotion-focused conversations with parents? *(please circle one)*

1	2	3	4	5
Poor	Minimal	Fair	Good	Very Good

13. How would you assess your own ability to develop and maintain relationships with parents? *(please circle one)*

1	2	3	4	5
Poor	Minimal	Fair	Good	Very Good

14. In general, how confident are you in having emotion-focused conversations with parents? *(please circle one)*

1	2	3	4	5
Not at all confident	A little confident	Somewhat confident	Quite confident	Very confident

15. Do you find yourself anxious about having emotion-focused conversations with parents?
(please circle one)

1	2	3	4	5
Not at all Anxious	A little anxious	Somewhat anxious	Quite anxious	Very anxious

Thank you very much!

APPENDIX G: PERCS POST-QUESTIONNAIRE – ADAPTED VERSION

(converted into an electronic version for this study)

Participant #: _____ Today's date: _____

Role during scenario: ___ participant ***or*** ___ observer

We would appreciate your responses to the following questions in an effort to better understand what issues are important to participants and to evaluate our training program. The questionnaire takes about twenty minutes to complete. Thank you very much.

1. Has the training program improved your sense of preparation to engage in emotion-focused conversations with parents? *(please circle one)*

a. Yes
b. No

2. In general, how prepared do you <u>now</u> consider yourself to be to have emotion-focused conversations with parents? *(please circle one)*

1	2	3	4	5
Not at all prepared	A little prepared	Somewhat prepared	Quite prepared	Very prepared

3. Has the training program improved your communication skills to engage in emotion-focused conversations with parents? *(please circle one)*

a. Yes
b. No

4. How would you <u>now</u> assess your own communication skills in having emotion-focused conversations with parents? *(please circle one)*

1	2	3	4	5
Poor	Minimal	Fair	Good	Very Good

5. Has the training program improved your ability to develop and maintain relationships with parents in the hospital setting? *(please circle one)*

a. Yes
b. No

6. How would you <u>now</u> assess your own ability to develop and maintain relationships with parents in the hospital setting? *(please circle one)*

1	2	3	4	5
Poor	Minimal	Fair	Good	Very Good

7. Has the training program improved your sense of confidence when engaging in emotion-focused conversations with parents? *(please circle one)*

a. Yes
b. No

8. In general, how confident are you *now* when having emotion-focused conversations with parents? *(please circle one)*

1	2	3	4	5
Not at all confident	A little confident	Somewhat confident	Quite confident	Very confident

9. Has the training program reduced your sense of anxiety when engaging in emotion-focused conversations with parents? *(please circle one)*

a. Yes
b. No

10. Do you *now* find yourself anxious about having emotion-focused conversations with parents? *(please circle one)*

1	2	3	4	5
Not at all anxious	A little anxious	Somewhat anxious	Quite anxious	Very anxious

11. Overall, how useful did you find the training program? *(please circle one)*

1	2	3	4	5
Not at all Useful	A little useful	Somewhat useful	Quite useful	Very useful

12. Overall, how would you rank the quality of the training program? *(please circle one)*

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

13. Were your expectations for the Nurse-Parent Emotion-Focused Communication training program exceeded, met, or unmet? *(please mark one and provide comments about your rating)*

___ Exceeded ___ Met ___ Unmet

Comments: _____

_____

_____

14. What were the most useful aspects of the Nurse-Parent Emotion-Focused Communication training program?

Comments: _____

_____

_____

_____

_____

15. What were the least useful aspects of the Nurse-Parent Emotion-Focused Communication training program?

Comments: _____

_____

_____

_____

_____

16. Would you recommend the program to others? *(please circle one)*

a. Yes
b. No

17. Do you have any suggestions or recommendations to improve the quality and usefulness of the Nurse-Parent Emotion-Focused Communication training program?

Comments: _____

_____

_____

_____

_____

Thank you very much!

APPENDIX H: POST-INTERVENTION FOLLOW-UP SURVEY

(converted into an electronic version for the study)

Please think of a time in the past two weeks where you used one or more of the Four Habits that you learned about in the communication training session. The experience may have been positive or negative. Please write down the story of that time.

APPENDIX I: PRE AND POST DEPENDENT VARIABLE MEANS

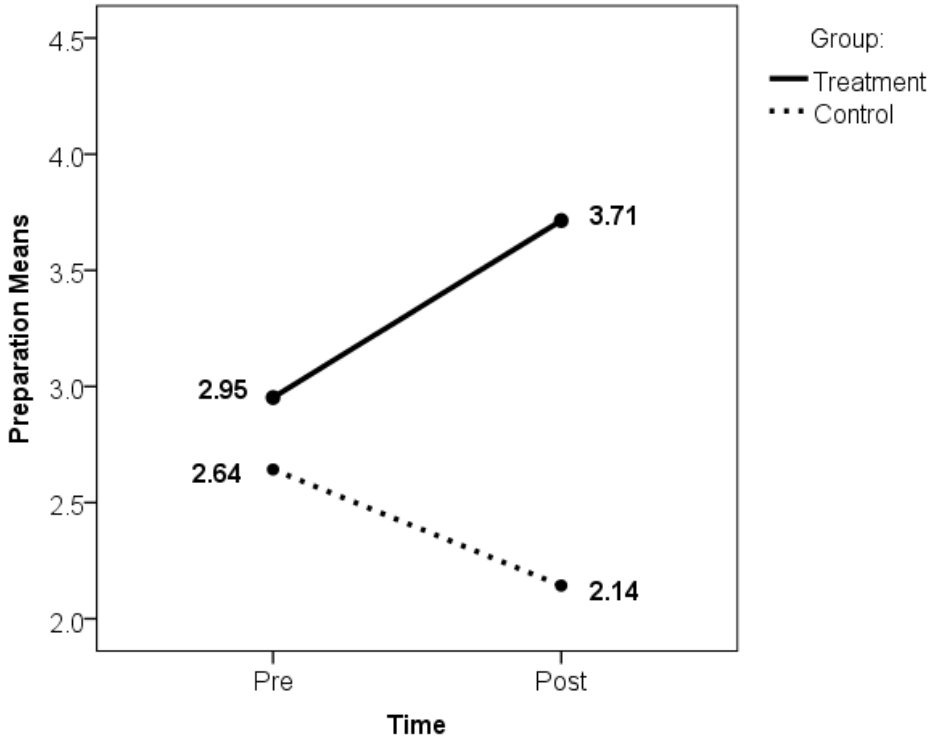

Figure I1. Preparation Means.

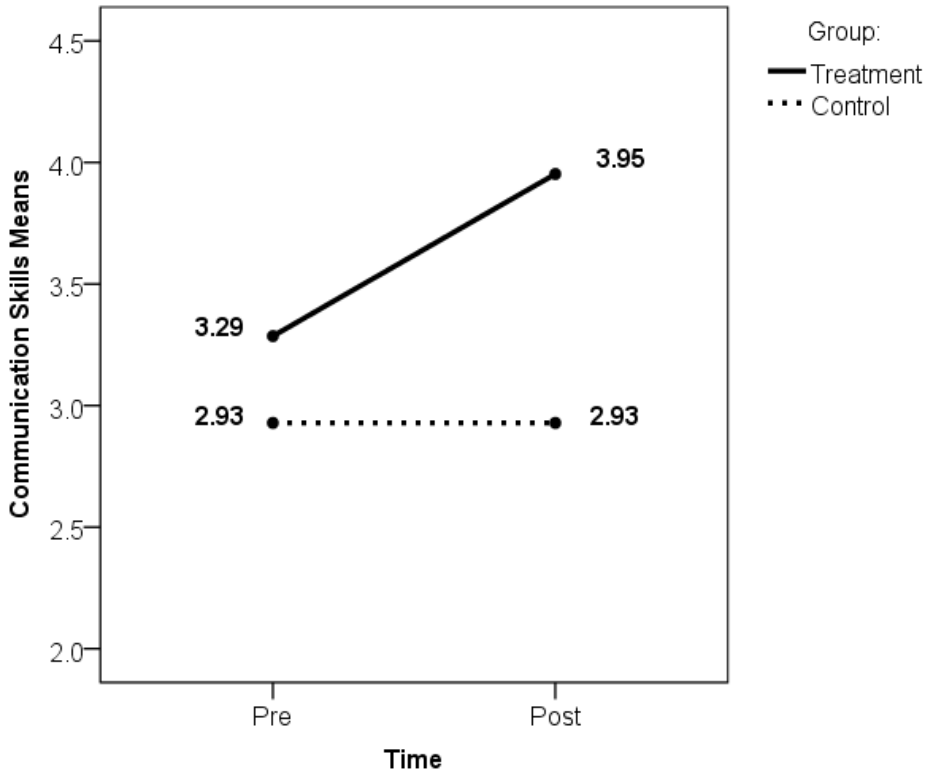

Figure I2. Communication Skills Means.

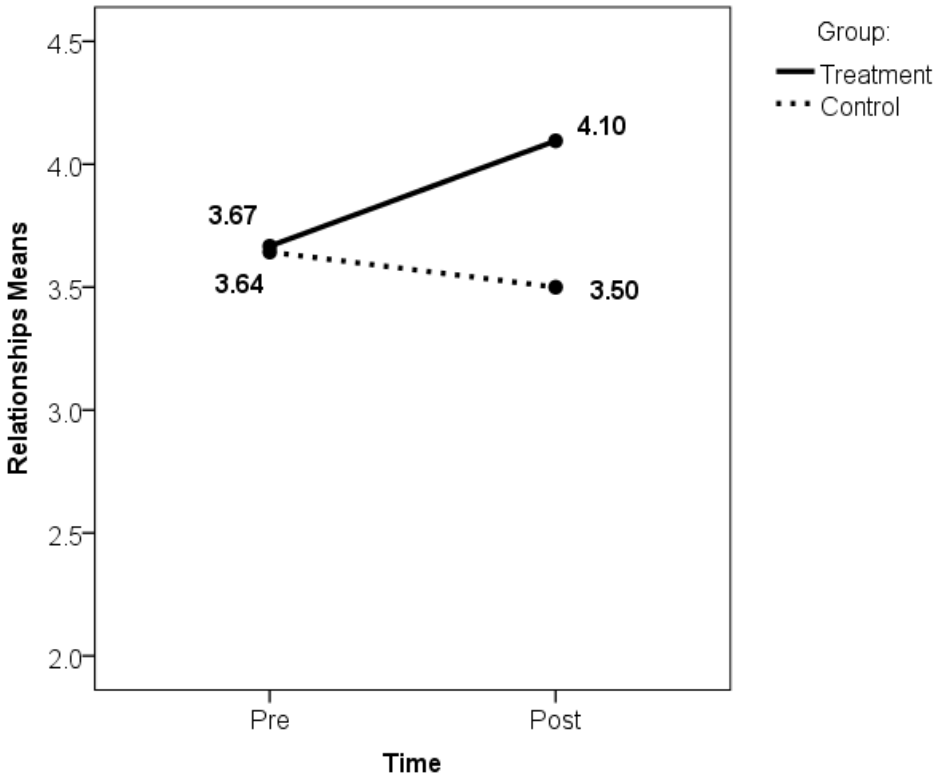

Figure I3. Relationships Means.

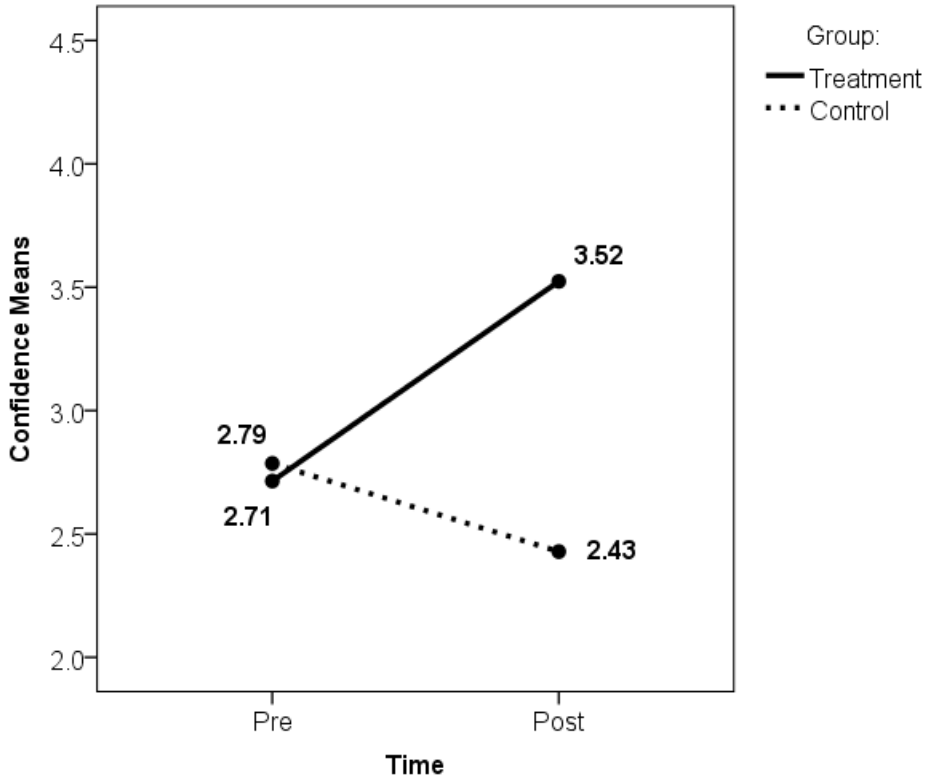

Figure I4. Confidence Means.

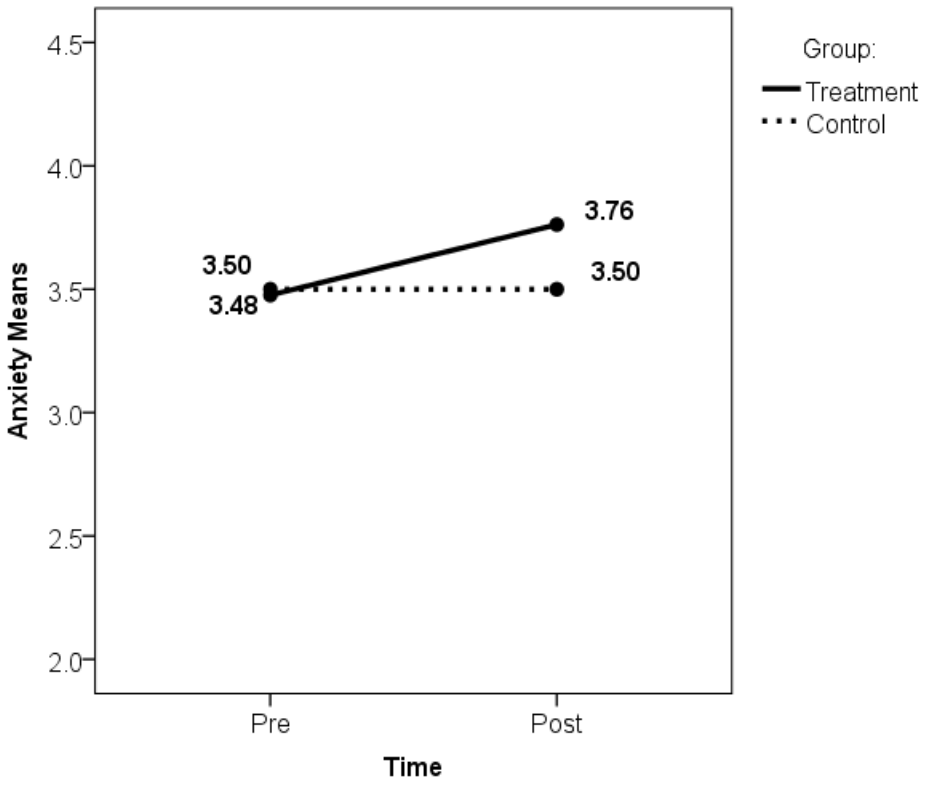

Figure I5. Anxiety Means.

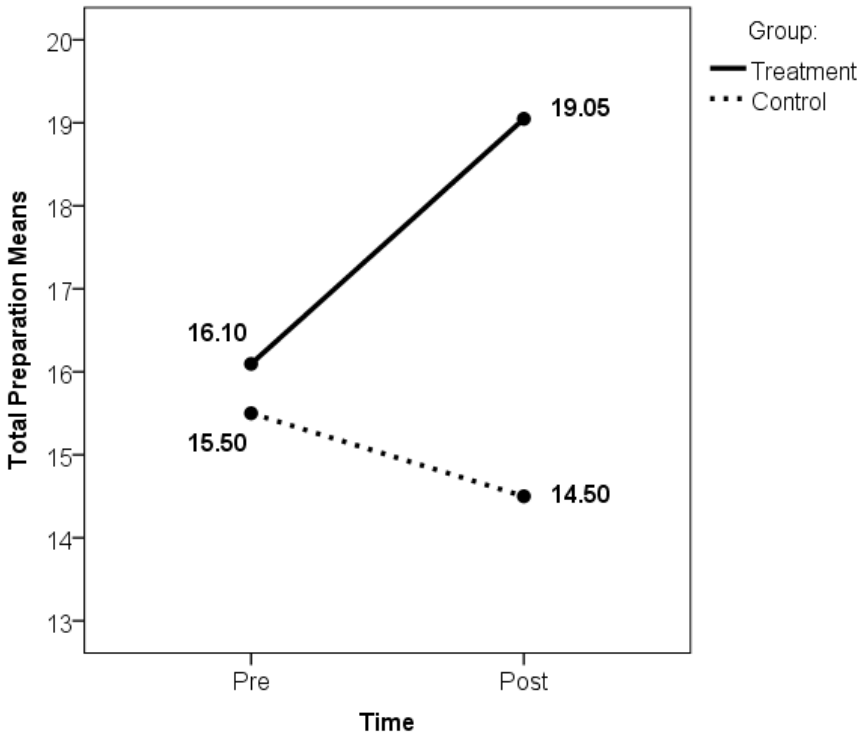

Figure I6. Total Preparation Means.

APPENDIX J: PRE AND POST DEPENDENT VARIABLE MEANS AND EXPERIENCE LEVEL

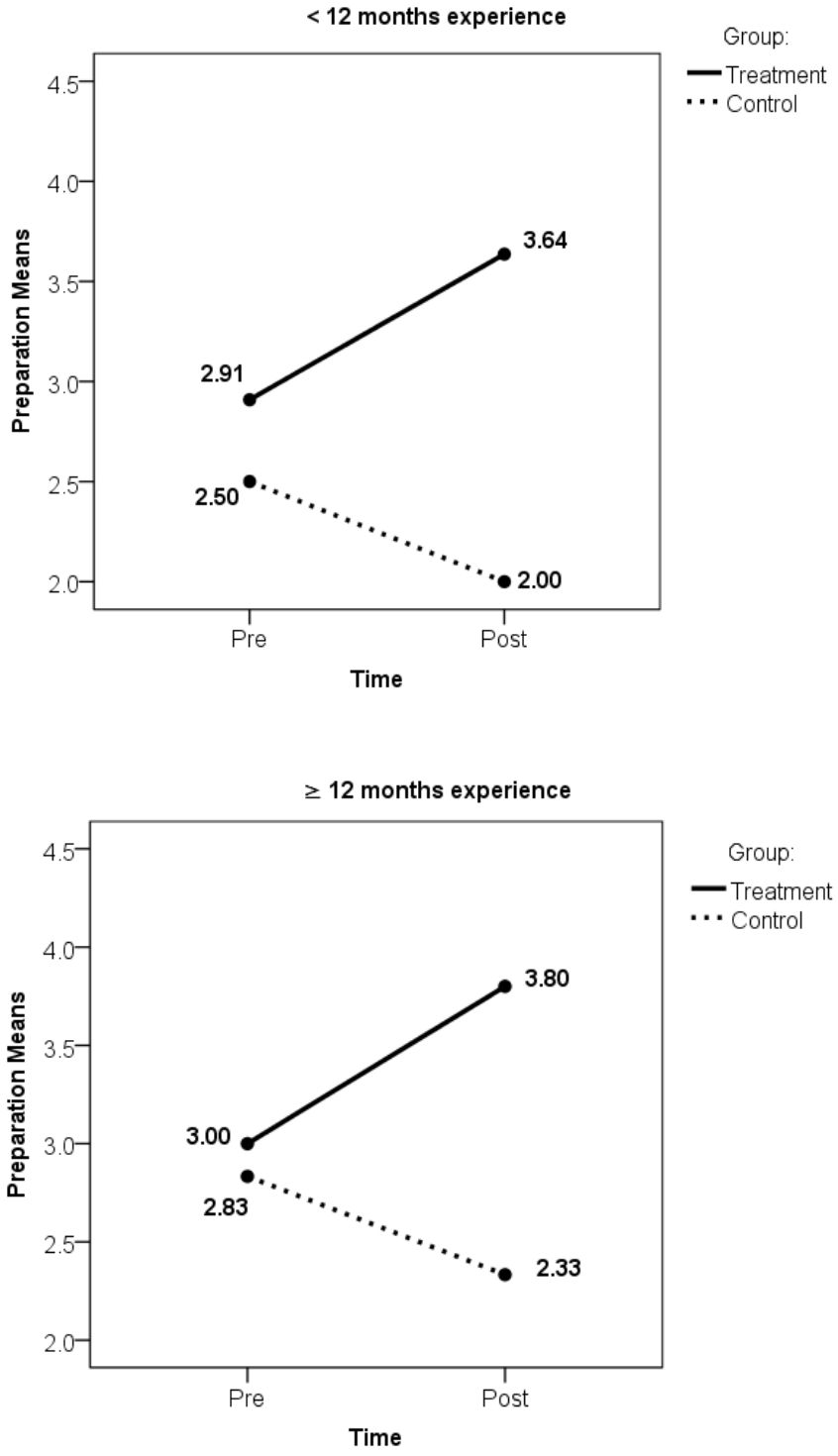

Figure J1. Preparation Means: Nurses < 12 Months and ≥ 12 Months RN Experience.

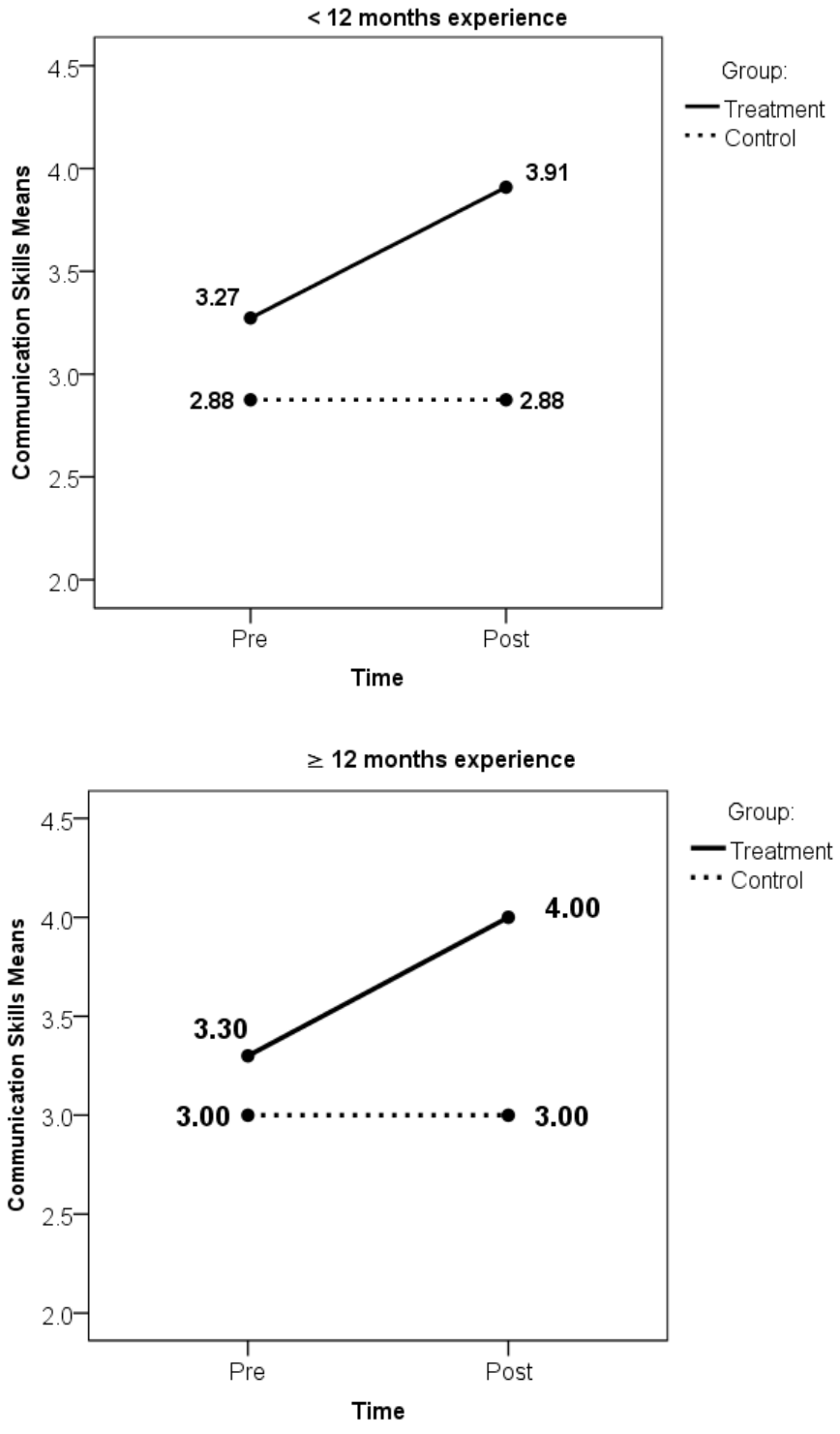

Figure J2. Communication Skills Means: Nurses < 12 Months and ≥ 12 Months RN Experience.

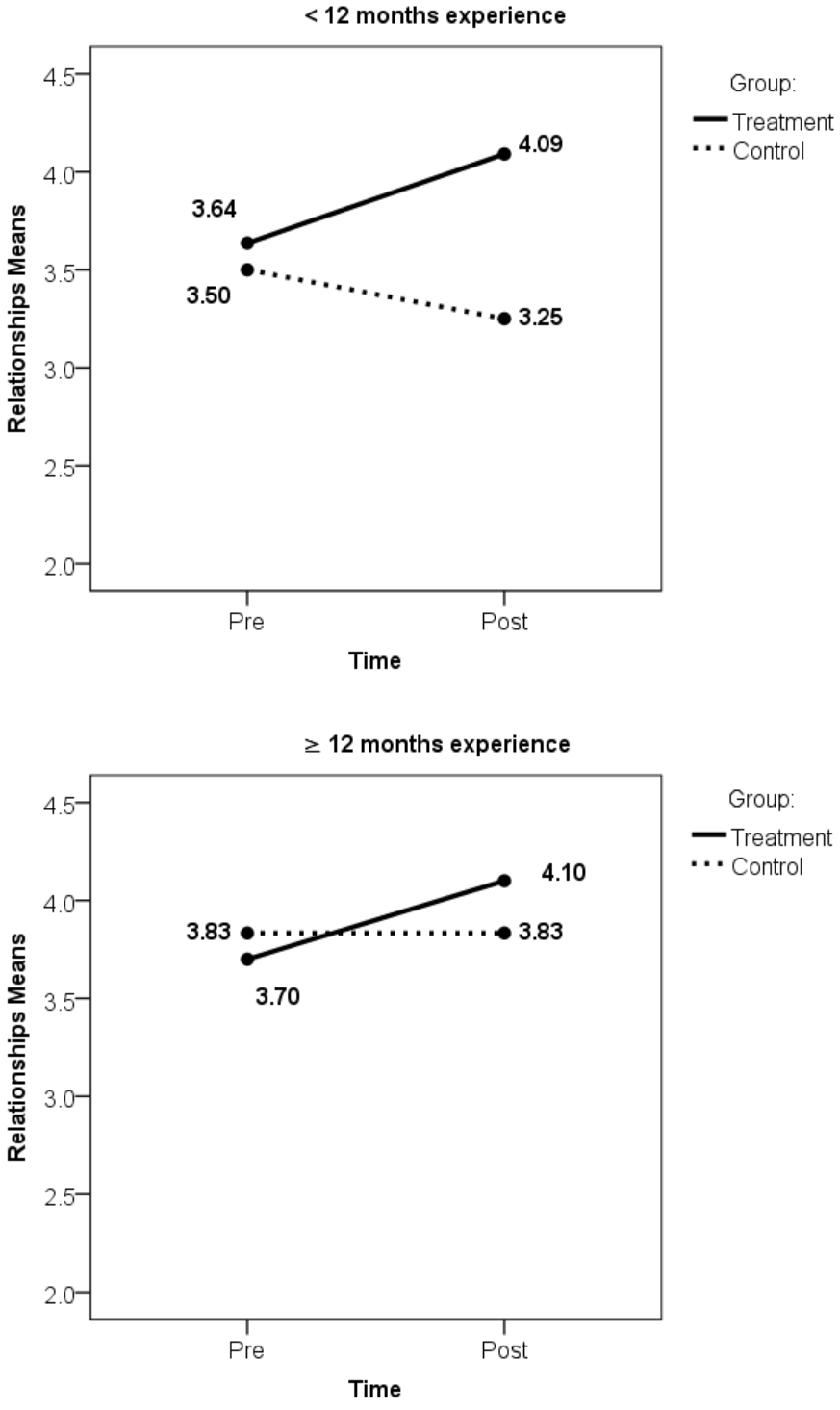

Figure J3. Relationships Means: Nurses < 12 Months and ≥ 12 Months RN Experience.

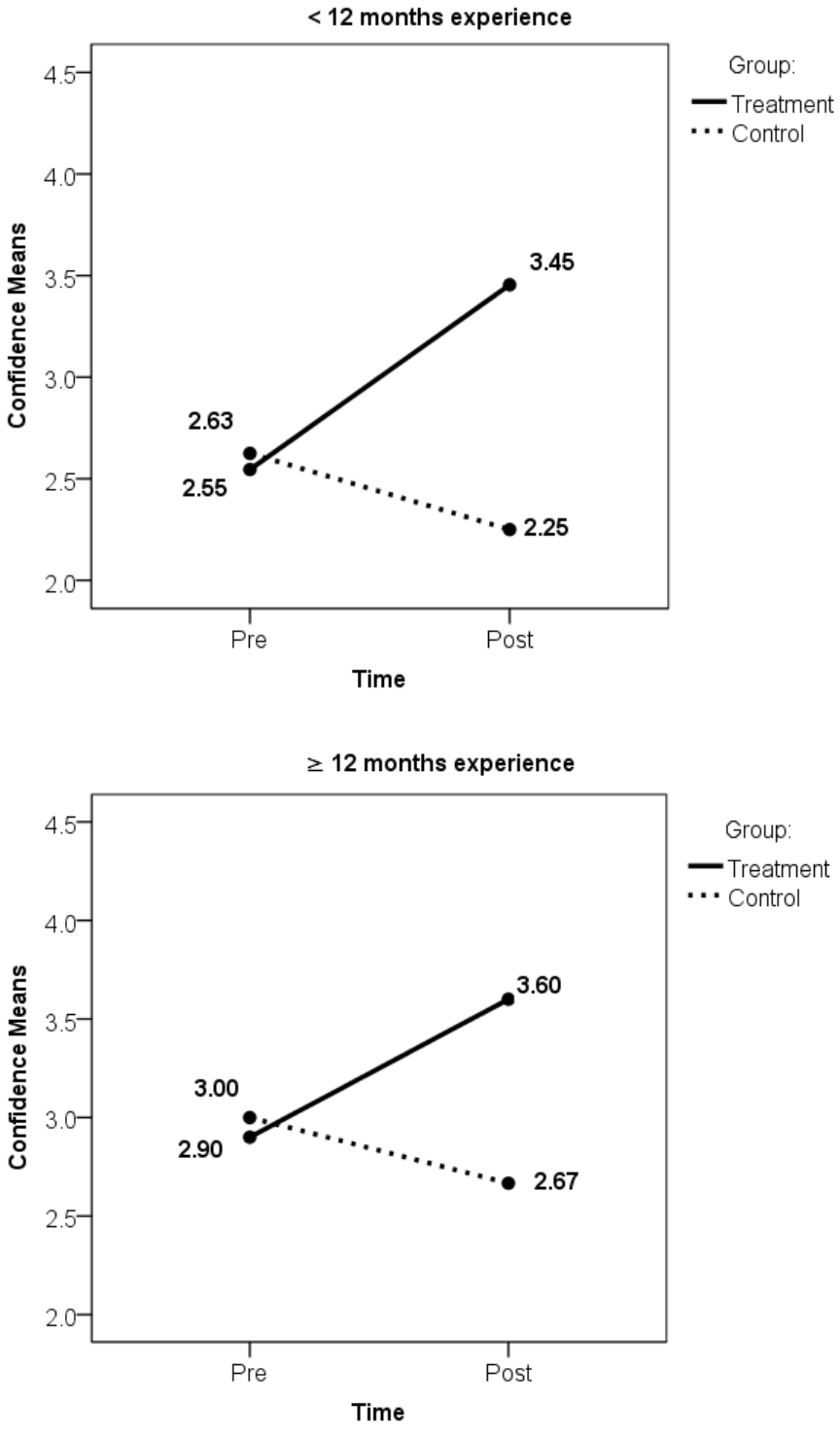

Figure J4. Confidence Means: Nurses < 12 Months and ≥ 12 Months RN Experience.

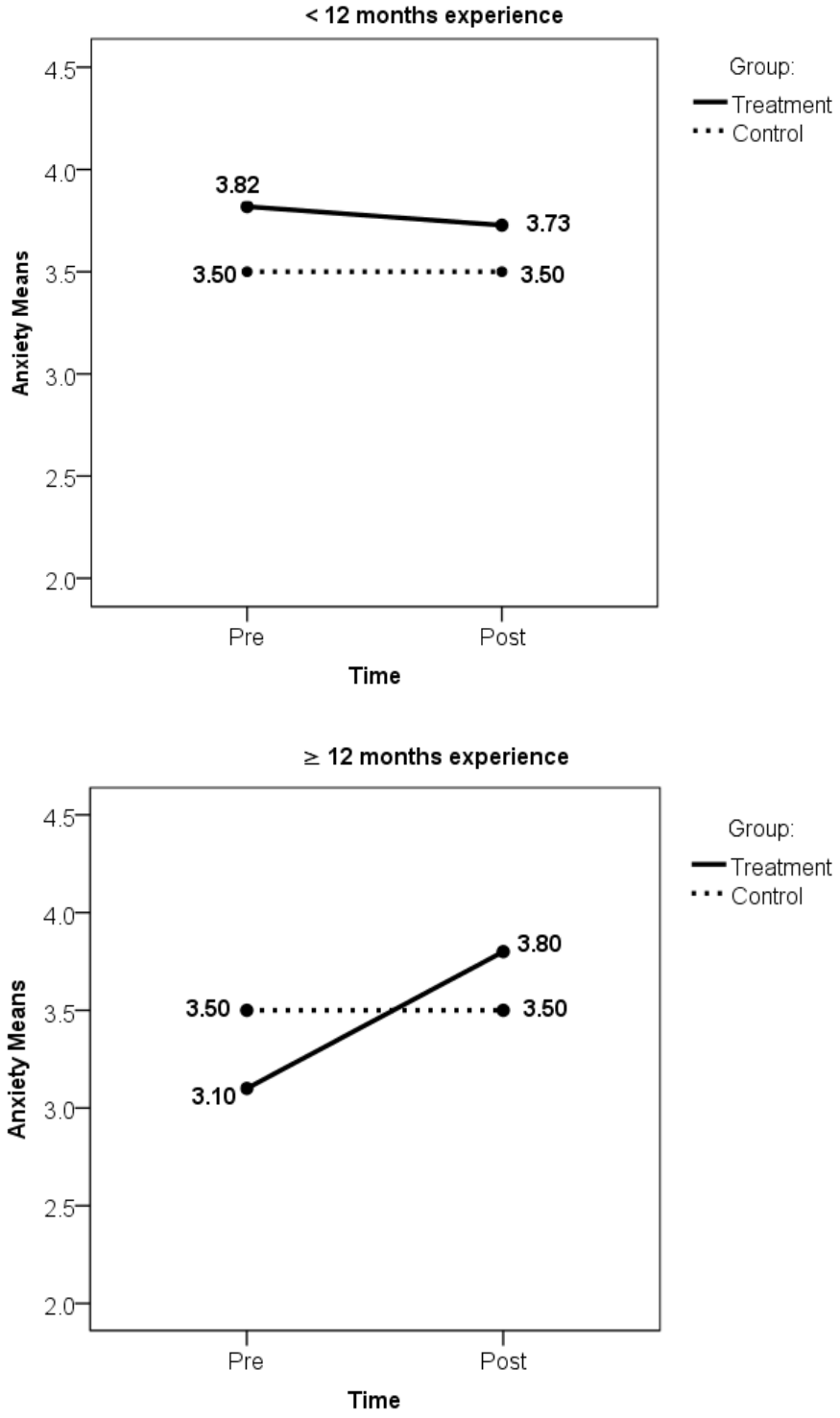

Figure J5. Anxiety Means: Nurses < 12 Months and ≥ 12 Months RN Experience.

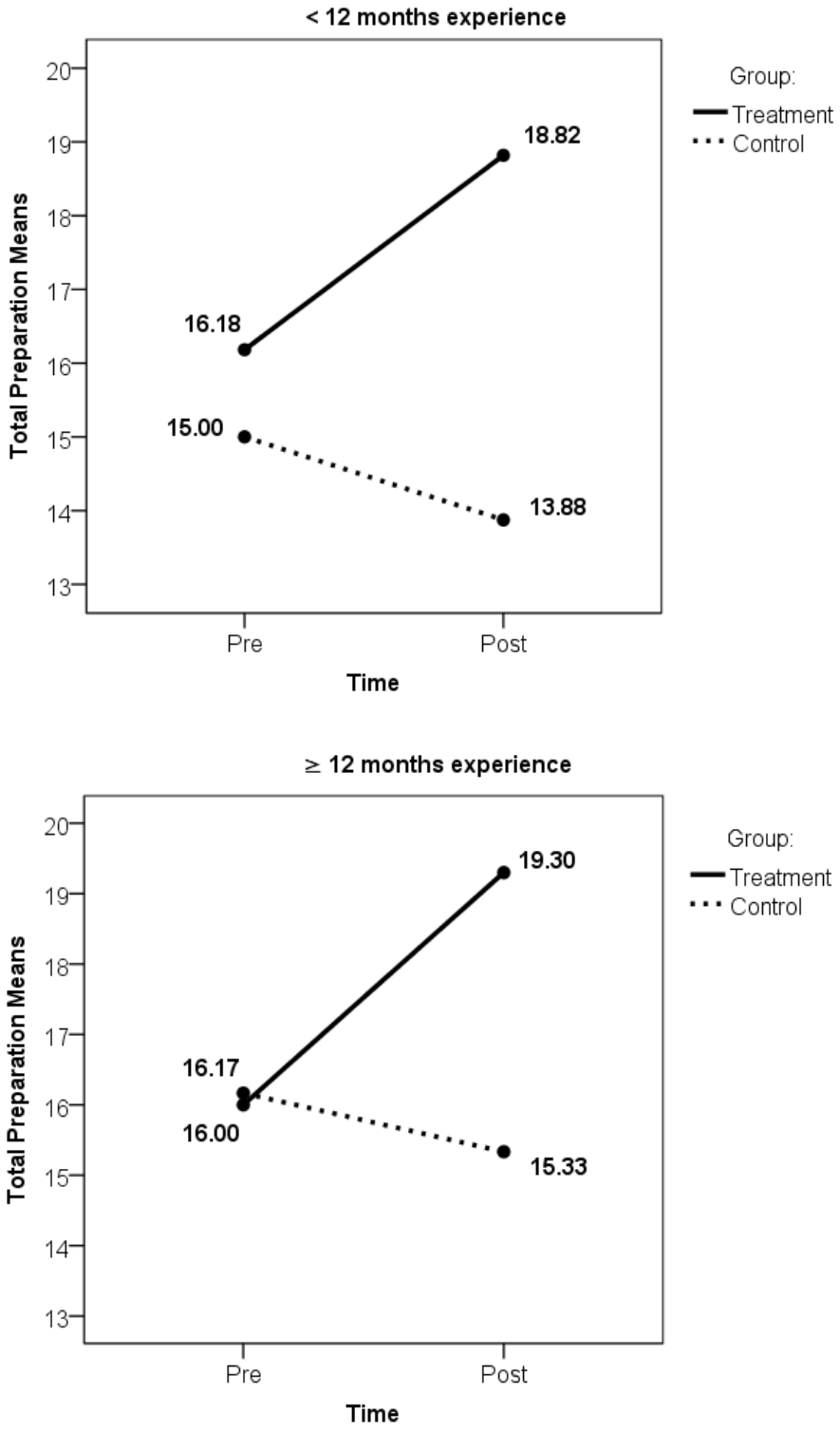

Figure J6. Total Preparation Means: Nurses < 12 Months and ≥ 12 Months RN Experience.

APPENDIX K: PERMISSIONS

Permission was granted from the authors (T. Stein, E. Krupat, and R. Frankel) to use and adapt the copyrighted Four Habits Model for this study. The Four Habits Model is proprietary to The Permanente Medical Group, Oakland, California.

Permission was granted from the authors (E. Krupat, R. Frankel, and T. Stein) to use and adapt the Four Habits Coding Scheme for this study. The Four Habits Coding Scheme is proprietary to The Permanente Medical Group, Oakland, California.

Permission was granted from the author (E. Meyer) to use and adapt the original Program to Enhance Relational and Communication Skills (PERCS) Pre-Questionnaire and PERCS Post-Questionnaire for this study.

REFERENCES

Aite, L., Zaccara, A., Trucchi, A., Nahom, A., Iacobelli, B., & Bagolan, P. (2006). Parents' informational needs at the birth of a baby with a surgically correctable anomaly. *Pediatric Surgery International, 22*(3), 267–270.

Ammentorp, J., Kirketerp, E., & Kofoed, P. E. (2009). Good communication has positive outcomes [Danish]. *Sygeplejersken / Danish Journal of Nursing, 109*(5), 60–62.

Ammentorp, J., & Kofoed, P. E. (2010). The long-term impact of a communication course for doctors and nurses: The parents' perspective. *Communication & Medicine, 7*(1), 3–10.

Ammentorp, J., Kofoed, P. E., & Laulund, L. W. (2010). Impact of communication skills training on parents perceptions of care: Intervention study. *Journal of Advanced Nursing, 67*(2), 394–400. doi:10.1111/j.1365-2648.2010.05475.x

Ammentorp, J., Mainz, J., & Sabroe, S. (2005). Parents' priorities and satisfaction with acute pediatric care. *Archives of Pediatrics & Adolescent Medicine, 159*(2), 127–131.

Ammentorp, J., Mainz, J., & Sabroe, S. (2006). Determinants of priorities and satisfaction in pediatric care. *Pediatric Nursing, 32*(4), 333–340.

Ammentorp, J., Sabroe, S., Kofoed, P. E., & Mainz, J. (2007). The effect of training in communication skills on medical doctors' and nurses' self-efficacy. *Patient Education and Counseling, 66*, 270-277.

Anderson, J. R. (2000). *Cognitive psychology and its implications* (5th ed.). New York, NY: Worth.

Angeles-Llerenas, A., Alvarez del Rio, A., Salazar-Martinez, E., Kraus-Weissman, A., Zamora-Munoz, S., Hernandez-Avila, M., & Lazcano-Ponce, E. (2003). Perceptions of nurses with regard to doctor-patient communication. *British Journal of Nursing, 12*(22), 1312–1321.

Astedt-Kurki, P., Paavilainen, E., Tammentie, T., & Paunonen-Ilmonen, M. (2001). Interaction between family members and health care providers in an acute care setting in Finland. *Journal of Family Nursing, 7*(4), 371–390.

Avis, M., & Reardon, R. (2008). Understanding the views of parents of children with special needs about the nursing care their child receives when in hospital: A qualitative study. *Journal of Child Health Care, 12*(1), 7–17.

Barry, M. J., & Edgman-Levitan, S. (2012). Shared decision making—Pinnacle of patient-centered care. *New England Journal of Medicine, 366*(9), 780–781.

Beach, M. C., Inui, T., & Relationship-Centered Care Research Network. (2006). Relationship-centered care. A constructive reframing. *Journal of General Internal Medicine, 21 Suppl 1*, S3–8.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. New York, NY: Addison-Wesley.

Benner, P. (2004). Using the Dreyfus Model of Skill Acquisition to describe and interpret skill acquisition and clinical judgment in nursing practice and education. *Bulletin of Science Technology Society, 24*(3), 188–199. doi:10.1177/0270467604265061

Benner, P., Tanner, C., & Chesla, C. (2009). *Expertise in nursing practice: Caring, clinical judgment, and ethics* (2nd ed.). New York, NY: Springer.

Benner, P., Tanner, C. A., Chesla, C. A., Dreyfus, H. L., Dreyfus, S. E., & Rubin, J. (1996). *Expertise in nursing practice: Caring, clinical judgment, and ethics*. New York, NY: Springer.

Berkow, S., Virkstis, K., Stewart, J., & Conway, L. (2008). Assessing new graduate nurse performance. *Journal of Nursing Administration, 38*(11), 468–474.

Berkow, S., Virkstis, K., Stewart, J., & Conway, L. (2009). Assessing new graduate nurse performance. *Nurse Educator, 34*(1), 17–22.

Betz, C. L. (2006). Parent-professional partnerships: Bridging the disparate worlds of children, families, and professionals. *Journal of Pediatric Nursing, 21*(5), 333–336.

Bidmead, C., & Cowley, S. (2005). A concept analysis of partnership with clients. *Community Practitioner, 78*(6), 203–208.

Blower, K., & Morgan, E. (2000). Great expectations? Parental participation in care. *Journal of Child Health Care, 4*(2), 60–65.

Board, R., & Ryan-Wenger, N. (2000). State of the science of parental stress and family functioning in pediatric intensive care units. *American Journal of Critical Care, 9*(2), 106–124.

Board, R., & Ryan-Wenger, N. (2002). Long-term effects of pediatric intensive care unit hospitalization on families with young children. *Heart & Lung, 31*(1), 53–66.

Brinchmann, B. S., Forde, R., & Nortvedt, P. (2002). What matters to the parents? A qualitative study of parents' experiences with life-and-death decisions concerning their premature infants. *Nursing Ethics, 9*(4), 388–404.

Brown, J., & Ritchie, J. A. (1990). Nurses' perceptions of parent and nurse roles in caring for hospitalized children. *Children's Health Care, 19*(1), 28–36.

Browning, D. M., Meyer, E. C., Truog, R. D., & Solomon, M. Z. (2007). Difficult conversations in health care: Cultivating relational learning to address the hidden curriculum. *Academic Medicine, 82*(9), 905–913.

Buford, T. A. (2005). School-age children with asthma and their parents: Relationships with health care providers. *Issues in Comprehensive Pediatric Nursing, 28*(3), 153–162.

Butz, A. M., Walker, J. M., Pulsifer, M., & Winkelstein, M. (2007). Shared decision making in school age children with asthma. *Pediatric Nursing, 33*(2), 111–116.

Callery, P., & Smith, L. (1991). A study of role negotiation between nurses and the parents of hospitalized children. *Journal of Advanced Nursing, 16*(7), 772–781.

Centers for Medicare & Medicaid Services. (2011). *HCAHPS (Hospital Care Quality Information from the Consumer Perspective) survey instruments*. Retrieved from http://www.hcahpsonline.org

Charles, C., Whelan, T., & Gafni, A. (1999). What do we mean by partnership in making decisions about treatment? *BMJ, 319*(7212), 780–782.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*(1), 155–159.

Copnell, B. (2005). Death in the pediatric ICU: Caring for children and families at the end of life. *Critical Care Nursing Clinics of North America, 17*(4), 349–360.

Corlett, J., & Twycross, A. (2006). Negotiation of parental roles within family-centered care: A review of the research. *Journal of Clinical Nursing, 15*(10), 1308–1316.

Coyne, I. (1995). Parental participation in care: A critical review of the literature. *Journal of Advanced Nursing, 21*(4), 716–722.

Coyne, I. (2006). Consultation with children in hospital: Children, parents' and nurses' perspectives. *Journal of Clinical Nursing, 15*(1), 61–71.

Coyne, I. (2007). Disruption of parent participation: Nurses' strategies to manage parents on children's wards. *Journal of Clinical Nursing, 17*(23), 3150–3158.

Coyne, I., & Cowley, S. (2006). Using grounded theory to research parent participation. *Journal of Research in Nursing, 11*(6), 501–515.

Cumbie, S. A. (2001). The integration of mind-body-soul and the practice of humanistic nursing. *Holistic Nursing Practice, 15*(3), 56–62.

Daneman, S., Macaluso, J., & Guzzetta, C. E. (2003). Healthcare providers' attitudes toward parent participation in the care of the hospitalized child. *Journal for Specialists in Pediatric Nursing, 8*(3), 90–98.

Darbyshire, P. (1993). Parents, nurses and paediatric nursing: A critical review. *Journal of Advanced Nursing, 18*(11), 1670–1680.

DeFrances, C. J., Lucas, C. A., Buie, V. C., & Golosinskiy, A. (2008). 2006 National Hospital Discharge Survey. *National Health Statistics Reports* (5), 1–20.

Dellasega, C., Milone-Nuzzo, P., Curci, K. M., Ballard, J. O., & Kirch, D. G. (2007). The humanities interface of nursing and medicine. *Journal of Professional Nursing, 23*(3), 174–179.

Diaz-Caneja, A., Gledhill, J., Weaver, T., Nadel, S., & Garralda, E. (2005). A child's admission to hospital: A qualitative study examining the experiences of parents. *Intensive Care Medicine, 31*(9), 1248–1254.

Dokken, D., & Ahmann, E. (2006). The many roles of family members in "family-centered care" - Part I. *Pediatric Nursing, 32*(6), 562–565.

Dokken, D., Simms, R., & Cole, F. S. (2007). The many roles of family members in "family-centered care" - Part II. *Pediatric Nursing 2007 January–February, 33*(1), 51–52, 70.

Dreyfus, H. L., & Dreyfus, S. E. (1986). *Mind over machine: The power of human intuition and expertise in the era of the computer*. New York, NY: Free Press.

Dreyfus, S. E. (2004). The five-stage model of adult skill acquisition. *Bulletin of Science Technology Society, 24*(3), 177–181. doi:10.1177/0270467604264992

Duchscher, J. E. (2001). Out in the real world: Newly graduated nurses in acute-care speak out [Erratum appears in *J Nurs Adm* 2001 Dec; 31(12):569]. *Journal of Nursing Administration, 31*(9), 426–439.

Dudek-Shriber, L. (2004). Parent stress in the neonatal intensive care unit and the influence of parent and infant characteristics. *American Journal of Occupational Therapy, 58*(5), 509–520.

Dudley, S. K., & Carr, J. M. (2004). Vigilance: The experience of parents staying at the bedside of hospitalized children. *Journal of Pediatric Nursing, 19*(4), 267–275.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129–136.

Engel, G. L. (1980). The clinical application of the biopsychosocial model. *The American Journal of Psychiatry, 137*(5), 535–544.

Espezel, H., & Canam, C. (2003). Parent-nurse interactions: Care of hospitalized children. *Journal of Advanced Nursing, 44*(1), 34–41.

Fallowfield, L., & Jenkins, V. (2004). Communicating sad, bad, and difficult news in medicine [Research support, non-U.S. Gov't]. *Lancet, 363*(9405), 312–319.

Fallowfield, L., Saul, J., & Gilligan, B. (2001). Teaching senior nurses how to teach communication skills in oncology. *Cancer Nursing, 24*(3), 185–191.

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39*(2), 175–191.

Fenton, M. V. (1987). Development of the Scale of Humanistic Nursing Behaviors. *Nursing Research, 36*(2), 82–87.

Fisher, M. J., & Broome, M. E. (2011). Parent-provider communication during hospitalization. *Journal of Pediatric Nursing, 26*(1), 58–69.

Fisher, M. J., Taylor, E. A., & High, P. L. (2012). Parent-nursing student communication practice: Role-play and learning outcomes. *Journal of Nursing Education, 51*(2), 115–119. doi:10.3928/01484834-20111216-04

Frampton, S. B., Gilpin, L., & Charmel, P. A. (Eds.). (2003). *Putting patients first: Designing and practicing patient-centered care*. San Francisco, CA: Jossey-Bass.

Frankel, R. M. (2004). Relationship-centered care and the patient-physician relationship. *Journal of General Internal Medicine, 19*(11), 1163–1165.

Frankel, R. M., & Stein, T. (1999). Getting the most out of the clinical encounter: The Four Habits Model. *The Permanente Journal, 3*(3), 79–88.

Frankel, R. M., & Stein, T. (2001). Getting the most out of the clinical encounter: The Four Habits Model. *Journal of Medical Practice Management, 16*(4), 184–191.

Gaba, D. (2004). The future vision of simulation in health care. *Quality and Safety in Health Care, 13*(Suppl 1), i2–i10.

Gilbert, D. A. (2004). Coordination in nurses' listening activities and communication about patient-nurse relationships. *Research in Nursing & Health, 27*(6), 447–457.

Girgis, A., & Sanson-Fisher, R. W. (1995). Breaking bad news: Consensus guidelines for medical practitioners [Review]. *Journal of Clinical Oncology, 13*(9), 2449–2456.

Glass, G. V., & Hopkins, K. D. (1996). *Statistical methods in education and psychology* (3rd ed.). Needham Heights, MA: Allyn & Bacon.

Gough, J. K., Frydenberg, A. R., Donath, S. K., & Marks, M. M. (2009). Simulated parents: Developing paediatric trainees' skills in giving bad news. *Journal of Paediatrics & Child Health, 45*(3), 133–138.

Gough, J. K., Johnson, L., Waldron, S., Tyler, P., & Donath, S. K. (2009). Clinical communication: Innovative education for graduate nurses in paediatrics. *Nurse Education in Practice, 9*(3), 209–214.

Gough, J. K., Roseby, R., & Marks, M. M. (2004). Rehearsing the art of clinical practice. *Medical Education, 38*(5), 557–558.

Gozzi, E. K., Morris, M. J., & Korsch, B. M. (1969). Gaps in doctor-patient communication. Implications for nursing practice. *American Journal of Nursing, 69*(3), 529–533.

Greenhouse, P. K., Kuzminsky, B., Martin, S. C., & Merryman, T. (2006). Calling a condition H(elp). *American Journal of Nursing, 106*(11), 63–66.

Greenwood, J. (2000). Critical thinking and nursing scripts: The case for the development of both. *Journal of Advanced Nursing, 31*(2), 428–436.

Griffin, T. (2003a). Facing challenges to family-centered care. I: Conflicts over visitation. *Pediatric Nursing, 29*(2), 135–137.

Griffin, T. (2003b). Facing challenges to family-centered care. II: Anger in the clinical setting. *Pediatric Nursing, 29*(3), 212–214.

Guevara, J. P., Feudtner, C., Romer, D., Power, T., Eiraldi, R., Nihtianova, S., . . . Schwarz, D. F. (2005). Fragmented care for inner-city minority children with attention-deficit/hyperactivity disorder. *Pediatrics, 116*(4), e512–517.

Gulbrandsen, P., Krupat, E., Benth, J. S., Garratt, A., Safran, D. G., Finset, A., & Frankel, R. (2008). "Four Habits" goes abroad: Report from a pilot study in Norway. *Patient Education and Counseling, 72*(3), 388–393.

Haines, C. (2005). Parents' experiences of living through their child's suffering from and surviving severe meningococcal disease. *Nursing in Critical Care, 10*(2), 78–89.

Hallstrom, I., Runeson, I., & Elander, G. (2002). An observational study of the level at which parents participate in decisions during their child's hospitalization. *Nursing Ethics: an International Journal for Health Care Professionals, 9*(2), 202–214.

Hammond, M., & McLean, E. (2009). What parents and carers think medical students should be learning about communication with children and families. *Patient Education and Counseling, 76*(3), 368–375.

Hanna, M., & Fins, J. J. (2006). Viewpoint: Power and communication: Why simulation training ought to be complemented by experiential and humanist learning. *Academic Medicine, 81*(3), 265–270.

Harbaugh, B. L., Tomlinson, P. S., & Kirschbaum, M. (2004). Parents' perceptions of nurses' caregiving behaviors in the pediatric intensive care unit. *Issues in Comprehensive Pediatric Nursing, 27*(3), 163–178.

Hopia, H., Tomlinson, P. S., Paavilainen, E., & Astedt-Kurki, P. (2005). Child in hospital: Family experiences and expectations of how nurses can promote family health. *Journal of Clinical Nursing, 14*(2), 212–222.

Hotchkiss, M. A., Biddle, C., & Fallacaro, M. (2002). Assessing the authenticity of the human simulation experience in anesthesiology. *AANA Journal, 70*(6), 470–473.

Hutchfield, K. (1999). Family-centered care: A concept analysis. *Journal of Advanced Nursing, 29*(5), 1178–1187.

Institute for Family-Centered Care. (2010). *FAQ: What is patient- and family-centered care?* Retrieved from http://www.familycenteredcare.org

Institute of Medicine of the National Academies. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: The National Academies Press.

Jackson, A. C., Stewart, H., O'Toole, M., Tokatlian, N., Enderby, K., Miller, J., & Ashley, D. (2007). Pediatric brain tumor patients: Their parents' perceptions of the hospital experience. *Journal of Pediatric Oncology Nursing, 24*(2), 95–105.

Jeffries, P. R. (2005). A framework for designing, implementing, and evaluating simulations used as teaching strategies in nursing. *Nursing Education Perspectives, 26*(2), 96–103. doi:10.1043/1536-5026

Jeffries, P. R. (2007). *Simulation in nursing education: From conceptualization to evaluation*. New York, NY: National League for Nursing.

Jeffries, P. R., Bambini, D., Hensel, D., Moorman, M., & Washburn, J. (2009). Constructing maternal-child learning experiences using clinical simulations. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 38*(5), 613–623.

Jeffries, P. R., & Rizzolo, M. A. (2006). *Designing and implementing models for the innovative use of simulation to teach nursing care of ill adults and children: A national, multi-site, multi-method study.* New York, National League for Nursing.

Johnson, A. M., Yoder, J., & Richardson-Nassif, K. (2006). Using families as faculty in teaching medical students family-centered care: What are students learning? *Teaching & Learning in Medicine, 18*(3), 222–225.

Kaakinen, J., & Arwood, E. (2009). Systematic review of nursing simulation literature for use of learning theory. *International Journal of Nursing Education Scholarship, 6*(1), 1–20.

Kameg, K., Mitchell, A. M., Clochesy, J., Howard, V. M., & Suresky, J. (2009). Communication and human patient simulation in psychiatric nursing. *Issues in Mental Health Nursing, 30*(8), 503–508.

King, S. (2007). *The Josie King story: Sorrel King's speech to IHI conference in Boston 2001* [DVD]: Texas Medical Institute of Technology. Retrieved from http://www.josieking.org/page.cfm?pageID=23.

King, S. (2009). *Josie's Story*. New York, NY: Atlantic Monthly Press.

Knowles, M. (1973). *The adult learner: A neglected species*. Houston, TX: Gulf.

Korsch, B. M., Gozzi, E. K., & Francis, V. (1968). Doctor-patient interaction and patient satisfaction. *Pediatrics, 42*(5), 855–871.

Krasner, M. S., Epstein, R. M., Beckman, H., Suchman, A. L., Chapman, B., Mooney, C. J., & Quill, T. E. (2009). Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA, 302*(12), 1284–1293.

Krippendorff, K. (1980). *Content analysis: An introduction to its methodology*. Beverly Hills, CA: Sage.

Kruijver, I. P. M., Kerkstra, A., Bensing, J. M., & van de Wiel, H. B. (2001). Communication skills of nurses during interactions with simulated cancer patients. *Journal of Advanced Nursing, 34*(6), 772–779.

Kruijver, I. P. M., Kerkstra, A., Kerssens, J. J., Holtkamp, C. C. M., Bensing, J. M., & van de Wiel, H. B. (2001). Communication between nurses and simulated patients with cancer: Evaluation of a communication training programme. *European Journal of Oncology Nursing, 5*(3), 140–153.

Krupat, E., Frankel, R., Stein, T., & Irish, J. (2006). The Four Habits Coding Scheme: Validation of an instrument to assess clinicians' communication behavior. *Patient Education & Counseling, 62*(1), 38–45.

Lam, L. W., Chang, A. M., & Morrissey, J. (2006). Parents' experiences of participation in the care of hospitalised children: A qualitative study. *International Journal of Nursing Studies, 43*(5), 535–545.

Lamiani, G., Meyer, E. C., Browning, D. M., Brodsky, D., & Todres, I. D. (2009). Analysis of enacted difficult conversations in neonatal intensive care. *Journal of Perinatology, 29*(4), 310–316.

Lamiani, G., Meyer, E. C., Leone, D., Vegni, E., Browning, D. M., Rider, E. A., . . . Moja, E. A. (2011). Cross-cultural adaptation of an innovative approach to learning about difficult conversations in healthcare. *Medical Teacher, 33*(2), e57–64.

Lasater, K. (2007). High-fidelity simulation and the development of clinical judgment: Students' experiences. *Journal of Nursing Education, 46*(6), 269–276.

Lee, P. (2007). What does partnership in care mean for children's nurses? *Journal of Clinical Nursing, 16*(3), 518–526.

Linder, L. (2009). Experiences of pediatric oncology nurses: The first year of hire. *Journal of Pediatric Oncology Nursing, 26*(1), 29–40.

Lutenbacher, M., Karp, S., Ajero, G., Howe, D., & Williams, M. (2005). Crossing community sectors: Challenges faced by families of children with special health care needs. *Journal of Family Nursing, 11*(2), 162–182.

Makoul, G. (2003). The interplay between education and research about patient-provider communication. *Patient Education & Counseling, 50*(1), 79–84.

Marshburn, D. M., Engelke, M. K., & Swanson, M. S. (2009). Relationships of new nurses' perceptions and measured performance-based clinical competence. *Journal of Continuing Education in Nursing, 40*(9), 426–432.

McCamant, K. L. (2006). Humanistic nursing, interpersonal relations theory, and the empathy-altruism hypothesis. *Nursing Science Quarterly, 19*(4), 334–338.

Messmer, P. R. (2008). Enhancing nurse-physician collaboration using pediatric simulation. *Journal of Continuing Education in Nursing, 39*(7), 319–327.

Meyer, E. C., Brodsky, D., Hansen, A. R., Lamiani, G., Sellers, D. E., & Browning, D. M. (2010). An interdisciplinary, family-focused approach to relational learning in neonatal intensive care. *Journal of Perinatology, 31*(3), 212–219.

Meyer, E. C., Sellers, D. E., Browning, D. M., McGuffie, K., Solomon, M. Z., & Truog, R. D. (2009). Difficult conversations: Improving communication skills and relational abilities in health care. *Pediatric Critical Care Medicine, 10*(3), 352–359.

Miller, G. A. (1956). The magical number seven plus or minus two: Some limits on our capacity for processing information. *Psychological Review, 63*(2), 81–97.

Montagnino, B. A., & Ethier, A. M. (2007). The experiences of pediatric nurses caring for children in a persistent vegetative state. *Pediatric Critical Care Medicine, 8*(5), 440–446.

Moore, J. B., & Kordick, M. F. (2006). Sources of conflict between families and health care professionals. *Journal of Pediatric Oncology Nursing, 23*(2), 82–91.

National Center for Health Statistics. (2009). *Health-United States-2008 with chartbook.* U.S. Government Printing Office. Retrieved from http://www.cdc.gov/

Neal, A., Frost, M., Kuhn, J., Green, A., Gance-Cleveland, B., & Kersten, R. (2007). Family centered care within an infant-toddler unit. *Pediatric Nursing, 33*(6), 481–485.

Nursing Executive Center. (2007). *The Nursing Executive Center New Graduate Nurse Performance Survey*. Washington, DC: Advisory Board Company.

O'Malley, P., Mace, S. E., & Brown, K. (2006). Patient- and family-centered care and the role of the emergency physician providing care to a child in the emergency department. *Annals of Emergency Medicine, 48*(5), 643–645.

Olson, M. E. (2009). The "millenials": First year in practice. *Nursing Outlook, 57*(1), 10–17.

Pagano, M., & Gauvreau, G. (2000). *Principles of biostatistics*. Pacific Grove, CA: Duxbury Thompson Learning.

Pellico, L. H., Brewer, C. S., & Kovner, C. T. (2009). What newly licensed registered nurses have to say about their first experiences. *Nursing Outlook, 57*(4), 194–203.

Platt, S. H. (1959). The welfare of children in hospital. *British Medical Journal, 1*(5115), 166, 167–169.

Plsek, P. E., & Greenhalgh, T. (2001). Complexity science: The challenge of complexity in health care. *BMJ, 323*(7313), 625–628.

Plsek, P. E., & Wilson, T. (2001). Complexity, leadership, and management in healthcare organisations. *BMJ, 323*(7315), 746–749.

Pongjaturawit, Y., Chontawan, R., Yenbut, J., Sripichyakan, K., & Harrigan, R. C. (2006). Parent participation in the care of hospitalized young children. *Thai Journal of Nursing Research, 10*(1), 18–28.

Power, N., & Franck, L. (2008). Parent participation in the care of hospitalized children: A systematic review. *Journal of Advanced Nursing, 62*(6), 622–641.

Price, J., McNeilly, P., & Surgenor, M. (2006). Breaking bad news to parents: The children's nurse's role. *International Journal of Palliative Nursing, 12*(3), 115–120.

Pyke-Grimm, K. A., Stewart, J. L., Kelly, K. P., & Degner, L. F. (2006). Parents of children with cancer: Factors influencing their treatment decision making roles. *Journal of Pediatric Nursing, 21*(5), 350–361.

Rao, J. K., Anderson, L. A., Inui, T. S., & Frankel, R. M. (2007). Communication interventions make a difference in conversations between physicians and patients: A systematic review of the evidence. *Medical Care, 45*(4), 340–349.

Rassin, M., Levy, O., Schwartz, T., & Silner, D. (2006). Caregivers' role in breaking bad news: Patients, doctors, and nurses' points of view. *Cancer Nursing, 29*(4), 302–308.

Raymond, D. P. (1995). Esthetic and personal knowing through humanistic nursing. *N & HC: Perspectives on Community, 16*(6), 332–336.

Reid, T., Bramwell, R., Booth, N., & Weindling, M. (2007). Perceptions of parent-staff communication in neonatal intensive care: The findings from a rating scale. *Journal of Neonatal Nursing, 13*(2), 64–74.

Roden, J. (2005). The involvement of parents and nurses in the care of acutely-ill children in a non-specialist paediatric setting. *Journal of Child Health Care, 9*(3), 222–240.

Rodriguez, H. P., Anastario, M. P., Frankel, R. M., Odigie, E. G., Rogers, W. H., von Glahn, T., & Safran, D. G. (2008). Can teaching agenda-setting skills to physicians improve clinical interaction quality? A controlled intervention. *BMC Medical Education, 8*, 3.

Rosenzweig, M., Hravnak, M., Magdic, K., Beach, M., Clifton, M., & Arnold, R. (2008). Patient communication simulation laboratory for students in an acute care nurse practitioner program. *American Journal of Critical Care, 17*(4), 364–372.

Roter, D., & McNeilis, K. (2003). The nature of the therapeutic relationship and the assessment of its discourse in routine medical visits. In T. Thompson, A. Dorsey, K. Miller, & R. Parrott (Eds.), *Handbook of health communication* (pp. 121–140). Mahwah, NJ: Lawrence Erlbaum Associates.

Safran, D. G., Miller, W., & Beckman, H. (2006). Organizational dimensions of relationship-centered care: Theory, evidence, and practice. *Journal of General Internal Medicine, 21*(Suppl 1), S9-S15.

Shannon, S. E., Long-Sutehall, T., & Coombs, M. (2011). Conversations in end-of-life care: Communication tools for critical care practitioners [Research Support, Non-U.S. Gov't]. *Nursing in Critical Care, 16*(3), 124-130. doi:10.1111/ j.1478-5153.2011.00456.x

Sherman, R. O. (2008). Factors influencing organizational participation in the clinical nurse leader project. *Nursing Economics, 26*(4), 236–242, 249.

Shields, L., Pratt, J., Davis, L., & Hunter, J. (2008). Family-centered care for children in hospital. *Cochrane Database of Systematic Reviews, 2007*(1). doi:10.1002/14651858.CD004811.pub2

Shields, L., Pratt, J., & Hunter, J. (2006). Family centered care: a review of qualitative studies. *Journal of Clinical Nursing, 15*(10), 1317–1323.

Simons, J., Franck, L., & Roberson, E. (2001). Parent involvement in children's pain care: View of parents and nurses. *Journal of Advanced Nursing, 36*(4), 591–599.

Simons, J., & Roberson, E. (2002). Poor communication and knowledge deficits: Obstacles to effective management of children's postoperative pain. *Journal of Advanced Nursing, 40*(1), 78–86.

Singleton, R. A. (1998). *Approaches to social research* (Vol. 3rd ed.). New York, NY: Oxford University Press.

Sobo, E. J. (2004). Pediatric nurses may misjudge parent communication preferences. *Journal of Nursing Care Quality, 19*(3), 253–262.

Stein, T. (2007). A decade of experience with a multiday residential communication skills intensive: Has the outcome been worth the investment? *Permanente Journal, 11*(4), 30–40.

Stein, T., Frankel, R. M., & Krupat, E. (2005). Enhancing clinician communication skills in a large healthcare organization: A longitudinal case study. *Patient Education and Counseling, 58*(1), 4–12.

Stein, T., Krupat, E., & Frankel, R. M. (2011). Talking with patients using the Four Habits Model. *Kaiser Permanente*. Oakland, CA: Madison Street Press.

Stewart, J. L., Pyke-Grimm, K. A., & Kelly, K. P. (2005). Parental treatment decision making in pediatric oncology. *Seminars in Oncology Nursing, 21*(2), 89–106.

Studdert, D. M., Burns, J. P., Mello, M. M., Puopolo, A. L., Truog, R. D., & Brennan, T. A. (2003). Nature of conflict in the care of pediatric intensive care patients with prolonged stay. *Pediatrics, 112*(3 Pt 1), 553–558.

Studer Group. (2010). *The nurse leader handbook: The art and science of nurse leadership*. Gulf Breeze, FL: Fire Starter.

Studer, Q., Robinson, B., & Cook, K. (2010). *The HCAHPS handbook: Hardwire your hosptial for pay-for-performance success*. Gulf Breeze, FL: Fire Starter.

Suchman, A. L. (2006). A new theoretical foundation for relationship-centered care: Complex responsive processes of relating. *Journal of General Internal Medicine, 21*(Suppl1), S40–S44.

Swenson, S. L., Buell, S., Zettler, P., White, M., Ruston, D. C., & Lo, B. (2004). Patient-centered communication: Do patients really prefer it? *Journal of General Internal Medicine, 19*(11), 1069–1079.

Tarini, B. A., Christakis, D. A., & Lozano, P. (2007). Toward family-centered inpatient medical care: The role of parents as participants in medical decisions. *Journal of Pediatrics, 151*(6), 690–695.

Teutsch, C. (2003). Patient-doctor communication. *Medical Clinics of North America, 87*(5), 1115–1145.

Thorne, S. E., & Robinson, C. A. (1988). Health care relationships: The chronic illness perspective. *Research in Nursing & Health, 11*(5), 293–300.

Tomlinson, P. (1981). *Understanding teaching: Interactive educational psychology*. London, England: McGraw-Hill.

Tomlinson, P. S., Thomlinson, E., Peden-McAlpine, C., & Kirschbaum, M. (2002). Clinical innovation for promoting family care in paediatric intensive care: Demonstration, role modelling and reflective practice. *Journal of Advanced Nursing, 38*(2), 161–170.

Toothaker, L. E. (1991). *Multiple comparisons for researchers*. Thousand Oaks, CA: Sage.

Ustun, B. (2006). Educational innovation. Communication skills training as part of a problem-based learning curriculum. *Journal of Nursing Education, 45*(10), 421–424.

Wangensteen, S., Johansson, I., & Nordstrom, G. (2008). The first year as a graduate nurse—An experience of growth and development. *Journal of Clinical Nursing, 17*(14), 1877–1885.

Wanzer, M. B., Booth-Butterfield, M., & Gruber, K. (2004). Perceptions of health care providers' communication: Relationships between patient-centered communication and satisfaction. *Health Communication, 16*(3), 363–383.

Wayman, K. I., Yaeger, K. A., Sharek, P. J., Trotter, S., Wise, L., Flora, J. A., & Halamek, L. P. (2007). Simulation-based medical error disclosure training for pediatric healthcare professionals. *Journal for Healthcare Quality, 29*(4), 12–19.

Wear, D., & Varley, J. D. (2008). Rituals of verification: The role of simulation in developing and evaluating empathic communication. *Patient Education & Counseling, 71*(2), 153–156.

Weissmann, P. F., Branch, W. T., Gracey, C. F., Haidet, P., & Frankel, R. M. (2006). Role modeling humanistic behavior: Learning bedside manner from the experts. *Academic Medicine, 81*(7), 661–667.

Williams, G. C., Frankel, R. M., Campbell, T. L., & Deci, E. L. (2000). Research on relationship-centered care and healthcare outcomes from the Rochester Biopsychosocial Program: A self-determination theory integration. *Families, Systems, & Health, 18*(1), 79–90.

Wills, A., & Wills, J. (2009). I wish you knew. *Pediatric Nursing, 35*(5), 318–321.

Wiseman, T. (1996). A concept analysis of empathy. *Journal of Advanced Nursing, 23*(6), 1162–1167.

Ygge, B. M., Lindholm, C., & Arnetz, J. (2006). Hospital staff perceptions of parental involvement in paediatric hospital care. *Journal of Advanced Nursing, 53*(5), 534–542.

Zavertnik, J. E., Huff, T. A., & Munro, C. L. (2010). Innovative approach to teaching communication skills to nursing students. *Journal of Nursing Education, 49*(2), 65–71. doi:10.3928/01484834-20090918-06

Ziv, A., Wolpe, P. R., Small, S. D., & Glick, S. (2003). Simulation-based medical education: An ethical imperative. *Academic Medicine, 78*(8), 783–788.

Zoppi, K., & Epstein, R. M. (2002). Is communication a skill? Communication behaviors and being in relation. *Family Medicine, 34*(5), 319–324.

CURRICULUM VITAE

NAME: Mark J. Fisher

EDUCATION

	Years attended	*Degree*	*Date*	*Major*
Indiana University at Indianapolis, Indiana	2006-2012	Doctor of Philosophy	2012	Major: Nursing Science Minor: Communication
The University of Oklahoma Health Sciences Center College of Nursing Oklahoma City, Oklahoma	1996-2000	Master of Science	2000	Nursing: Education
Baylor University School of Nursing Dallas, Texas	1992-1994	Bachelor of Science	1994	Nursing
Bentley College Waltham, Massachusetts	1984-1986	Bachelor of Science	1986	Management

PROFESSIONAL EXPERIENCE

Academic/Research

Position	*Institution*	*Inclusive Dates*
Core Faculty – Nursing Center for Interdisciplinary Learning and Leadership – Oklahoma LEND	The University of Oklahoma Health Sciences Center College of Medicine Oklahoma City, Oklahoma Oklahoma LEND: Maternal Child Health Interdisciplinary Leadership Grant # T73 MC 00033	July 2010 – Present *(LEND Fellow since 1998)*
Faculty – Instructor	The University of Oklahoma Health Sciences Center College of Nursing Oklahoma City, Oklahoma	December 2001 – Present

Nurse Interventionist Project title: *A Clinic-Based Interdisciplinary Intervention for Parents of Children with Cancer*	The University of Oklahoma Health Sciences Center College of Nursing NINR R21 funded project Grant # 1 R21 NR010103-01	June 2008 – August 2010
Instructional Faculty Center for Interdisciplinary Learning and Leadership – Oklahoma LEND	The University of Oklahoma Health Sciences Center College of Medicine Oklahoma City, Oklahoma	December 2001 – July 2010
Core Faculty – Instructor OUHSC Interdisciplinary Seminar and assisted with IRB approved research project: *Learner Attitudes Toward Interdisciplinary Health Care Teams*	The University of Oklahoma Health Sciences Center College of Nursing	February 2005 – May 2006 *(Summer 2005 pilot seminar)*
Subject Matter Expert Subject: Clinical Nursing I	ORBIS Education Fishers, Indiana (contract – an extension of The University of Oklahoma Health Sciences Center College of Nursing)	May 2005 – January 2006
Research Assistant Project title: *The Effects of An Academic Course on Student Nurse Attitudes Toward People With Disabilities*	The University of Oklahoma Health Sciences Center College of Nursing	Fall 2003 – Spring 2005
Research Coordinator Project title: *Sooner Care Health Education Partners Focus Group*	The University of Oklahoma Health Sciences Center College of Medicine Oklahoma City, Oklahoma	Summer 2001 – Fall 2001
Course Attendee *University of Oklahoma Good Clinical Practice (GCP)* two-day course for research coordinators	The University of Oklahoma Health Sciences Center College of Medicine Oklahoma City, Oklahoma	January 2001

Research Assistant Project title: *Sooner Care Health Education Partners Focus Group*	The University of Oklahoma Health Sciences Center College of Medicine Oklahoma City, Oklahoma	Fall 2000
Training Coordinator Center for Interdisciplinary Learning and Leadership – *SoonerCare* Health Education Partners project (SCHEP)	The University of Oklahoma Health Sciences Center College of Medicine Oklahoma City, Oklahoma	November 2000 – November 2001
Volunteer Adjunct Faculty	The University of Oklahoma Health Sciences Center College of Nursing Oklahoma City, Oklahoma	Spring 1999
Graduate Teacher's Assistant With Anita C. All, Ph.D., R.N., Associate Professor	The University of Oklahoma Health Sciences Center College of Nursing Oklahoma City, Oklahoma	August 1999 – October 1999
Graduate Research Assistant With Anita C. All, Ph.D., R.N., Associate Professor	The University of Oklahoma Health Sciences Center College of Nursing Oklahoma City, Oklahoma	September 1998 – May 1999

Clinical

Staff Registered Nurse (part-time) Pediatric Emergency Room and Post Anesthesia Care Unit	The University of Oklahoma Medical Center - Children's Hospital Oklahoma City, Oklahoma	May 2003 – January 2004
Staff Registered Nurse (part-time) Pediatric Medical-Surgical Unit/Floor	The University of Oklahoma Medical Center – Children's Hospital Oklahoma City, Oklahoma	May 2002 – July 2002
Registered Nurse III Developmental Disability Services Division	The State of Oklahoma Department of Human Services Norman, Oklahoma	April 1998 – October 2000
Staff Nurse OptionCare of Norman & Norman Regional Home Health	Norman Regional Hospital Norman, Oklahoma	July 1995 – April 1998

Staff/Charge Nurse Kidney/Liver Transplant and Medical Intensive Care Unit	Baylor University Medical Center Dallas, Texas	May 1994 – June 1995
Clinical Student Nurse (part-time) Medical Intensive Care Unit	Baylor University Medical Center Dallas, Texas	March 1994 – May 1994
Research Assistant (part-time) Baylor Medical Institute	Baylor University Medical Center Dallas, Texas	April 1993 – March 1994

Other Professional – Business

Concierge Pediatric Hospital	Children's Medical Center Dallas, Texas	February 1991 – January 1993
Admissions Counselor Modeling Agency	La Belle Santa Barbara, California	May 1990 – October 1990
Seminar Coordinator & Sales Financial Consulting Firm	Mercer Santa Barbara, California	May 1988 – April 1990
Service & Sales Manager Furniture Store	Chap de Laines South Hadley, Massachusetts	May 1987 – September 1987
Manager Restaurant	The Oyster Club Dover, New Hampshire	May 1986 – April 1987

CERTIFICATIONS

CPR Certification	Certificate re-issued 2011
Myers-Briggs Type Indicator Training Certification	Certificate issued 2001

LICENSES

Oklahoma	Registered Nurse – Issued 1995	Active/Current (October 2014)
Texas	Registered Nurse – Issued 1994	Inactive –1996 (moved out of state)

MEMBERSHIPS

2011 – Present	Member, Association of Standardized Patient Educators (national)

2007 – Present	Member, Society of Pediatric Nurses (national)
2006 – Present	Member, Midwest Nursing Research Society (regional)
2002 – Present	Member, Cleveland County Turning Point (local)
1998 – Present	Member, Sigma Theta Tau International, Beta Delta Chapter-at-Large (local/regional/international)

HONORS AND AWARDS

2011 Received "Research Grant Award" from Sigma Theta Tau International Beta Delta Chapter-at-Large during fall 2011 Sigma Theta Tau International Beta Delta Chapter-at-Large induction ceremony in Oklahoma City, Oklahoma on November 18, 2011

2010 Selected as the "Most Inspirational Clinical Instructor" by the senior undergraduate students at the University of Oklahoma College of Nursing. Awards Ceremony and Banquet 2010 in Norman, Oklahoma on May 13, 2010

2009 Received the "Health Sciences Center Outstanding Student Organization Adviser of the Year" award. OUHSC Student Association Big Event Executive Committee on April 20, 2009

2009 Received the "Excellence in Clinical Instruction" award by the senior undergraduate students at the University of Oklahoma College of Nursing. Awards Ceremony and Banquet 2009 in Norman, Oklahoma on May 14, 2009

2008 Selected as the "Most Inspirational Clinical Instructor" by the senior undergraduate students at the University of Oklahoma College of Nursing. Awards Ceremony and Banquet 2008 in Norman, Oklahoma on May 8, 2008

2007 Selected as the "Most Inspirational Clinical Instructor" by the senior undergraduate students at the University of Oklahoma College of Nursing. Awards Ceremony and Banquet 2007 in Norman, Oklahoma on May 10, 2007

2006 Selected as the "Most Organized Faculty" by the undergraduate students at the University of Oklahoma College of Nursing. Awards Ceremony and Banquet 2006 in Norman, Oklahoma on May 11, 2006

2005 Appointed associate member of Graduate Faculty in Nursing (initial appointment 2005); three-year renewal updated 2011 (approved through 2014)

2005 Selected as a member of "Who's Who in Teaching – 2005" July 2005

2004 Selected as "Best Junior Clinical Instructor – 2004" by the undergraduate students at the University of Oklahoma College of Nursing. 2004 Award Ceremony and Banquet, Norman, Oklahoma on May 6, 2004

2004 Received "Certificate of Appreciation" from the Class of 2004 in recognition of distinguished service, commitment to excellence and nursing spirit for the University of Oklahoma College of Nursing. Norman, Oklahoma on May 6, 2004

2002 Selected to participate in the "OUHSC Faculty Leadership Program" The University of Oklahoma Health Sciences Center. Oklahoma City, Oklahoma, Initial Orientation August 2002 concluding with graduation on June 17, 2004

2002 Received "The Essence of Leadership" (plaque) from undergraduate clinical group of NURS 4126 Clinical Nursing IV students at the University of Oklahoma College of Nursing at the Health Sciences Center. Oklahoma City, Oklahoma on May 2002

2001 Received "Outstanding Community Service," "Outstanding Research," and "Student Government," exceptional performance certificates from the University of Oklahoma College of Nursing at the Health Sciences Center. Oklahoma City, Oklahoma on May 10, 2001

2000 "Distinguished Leadership Citation" from Herbert Nishikawa, Ph.D., R.N. Faculty Advisor of the Graduate Student Nursing Association at the University of Oklahoma College of Nursing at the Health Sciences Center. Oklahoma City, Oklahoma, May 2000

2000 Received "Integrity" (plaque) from current officers of the Graduate Student Nurses Association at the University of Oklahoma College of Nursing at the Health Sciences Center. Oklahoma City, Oklahoma, May 2000

1999 Selected as a member of "Who's Who Among Students In American Universities & Colleges," The University of Oklahoma College of Nursing at the Health Sciences Center. Oklahoma City, Oklahoma, 1999

1997 Selected to participate in Oklahoma LEND as an Intern with the University of Oklahoma Health Sciences Center College of Medicine at the Center for Learning and Leadership. Oklahoma City, Oklahoma, August 1997 – May 1998 (LEND: Interdisciplinary Leadership Education for Health Professionals Caring for Children with Neurodevelopmental and Related Disabilities)

1994 Baylor University School of Nursing, Selected by fellow students to be a Co-Speaker for the Pinning Ceremony. Dallas, Texas, May 1994

1993 Children's Medical Foundation, James Farnsworth Health Careers Scholarship recipient, Dallas, Texas

1992 Children's Medical Foundation, James Farnsworth Health Careers Scholarship recipient, Dallas, Texas

RESEARCH

Summer 2011 – Present	Primary Investigator at the University of Oklahoma Health Science Center and Co-Investigator working with Dr. Marion E. Broome as a student at Indiana University Purdue University at Indianapolis School of Nursing, OUHSC and IUPUI IRB approved, and currently conducting quantitative research project involving an intervention aimed at improving newly licensed pediatric nurse's communication with parents OUHSC IRB and IUPUI IRB project title: A Brief Intervention to Improve Emotion-Focused Communication Between Newly Licensed Pediatric Nurses and Parents (funding provide by Sigma Theta Tau International Beta Delta Chapter-at Large)
Spring 2008 – Fall 2009	Primary Investigator at the University of Oklahoma Health Science Center and Co-Investigator working with Dr. Marion E. Broome as a student at Indiana University Purdue University at Indianapolis School of Nursing, conducted a pilot qualitative research project exploring communication between parents of children with chronic illnesses, nurses, and doctors in the inpatient hospital setting OUHSC IRB and IUPUI IRB project title: *Parent-Nurse Communication in Pediatric Nursing* (non-funded)

PUBLICATIONS *(*peer-reviewed; +data-based)*

* Fisher, M. J., Taylor, E. A., & High, P. L. (2012). Parent-nursing student communication practice: role-play and learning outcomes. *Journal of Nursing Education, 51*(2), 115-119. doi:10.3928/01484834-20111216-04

+*Fisher, M.J. & Broome, M.E. (2011). Parent-provider communication during hospitalization. *Journal of Pediatric Nursing*. 26(1), pp. 58-69. doi:10.1016/j.pedn.2009.12.071

*Fisher, M.J. (2006). One-minute paper. *Journal of Nursing Education*. 45(7). pp. 287-288.

*All, A.C., Huycke, L.I. & Fisher, M.J. (2003). Instructional Tools for Nursing Education: Concept Maps. National League for Nursing: *Nursing Education Perspectives*. 24 (6). pp. 311-317.

Fisher, M.J. (2003). From student to teacher: My path to my role as a facilitator of learning. *Baylor University College of Nursing Alumni Newsletter*. Spring/Summer.

All, A.C. & Fisher, M.J. (2002). Undetectable: The new face of aids (film review). *Science Books & Films*. December.

Fisher, M. (2002). President's letter. *Sigma Theta Tau International Beta Delta Chapter-At-Large Newsletter*. Spring.

Fisher, M., Martin, V. & Worley, L. (2000). A focus group report on medicaid managed care in urban Oklahoma: Results of interviews with families of children with disabilities. *Center for Learning and Leadership* Oklahoma City, Oklahoma *Center for Learning and Leadership* (Oklahoma's federally designated University Center for Excellence in Developmental Disabilities, Education, Research and Service), College of Medicine, University of Oklahoma Health Sciences Center.

Fisher, M. and Martin, V. (2000). Learning how to use managed health care: A training guide on medicaid managed care in oklahoma. *Center for Learning and Leadership* Oklahoma City, Oklahoma (Oklahoma's federally designated University Center for Excellence in Developmental Disabilities, Education, Research and Service), College of Medicine, University of Oklahoma Health Sciences Center.

PRESENTATIONS

Parent-Provider Communication in the Complex Care Environment (podium presentation). Midwestern Nursing Research Society annual research conference. Minneapolis, Minnesota. March 28, 2009.

State of the Science in Pediatric Nursing: Interventions for Asthma Self-management; Parent-Provider Communication; and Interventions for Obesity in Childhood (podium presentation). Broome, M.; Crowder, S.; Fisher, M.; & Seal, L. Midwest Nursing Research Society Pre-conference, Minneapolis, Minnesota. March 27, 2009.

Individual Health Systems Advocacy (podium presentation). Interdisciplinary Leadership Issues II: Disability Advocacy for the 2007-2008 Oklahoma LEND Leadership Interns. Oklahoma City, Oklahoma, March 6, 2008.

Interdisciplinary Seminar Promotes Heath Care Teamwork and Influences Learner Attitudes Toward Interdisciplinary Health Care Teams (podium presentation). Fisher, M.J. & Van Grevenhof, J. National League for Nursing Education Summit 2006: Transformation Begins with You in New York City, New York, Friday, September 29, 2006.

Concept Mapping (podium presentation). Huycke, L., Fisher, M. J., & All, A. C. Oklahoma Association of Community Colleges Building Pathways to the Future at the Kerr Conference Center. Poteau, Oklahoma, March 4, 2004.

Practical Experiences with an Educational Tool: Concept Maps (podium presentation). Fisher, M. J., Miller-Boyle, D., Kientz, E. & Edwards, K. The University of Oklahoma Health Sciences Center College of Nursing Faculty Development Day. Oklahoma City, Oklahoma, January 7, 2004.

Concept/Cognitive Maps (podium presentation). Fisher, M. J., Huycke, L., & All, A. C. Oklahoma Global Education Consortium Sixth Annual Global Education Conference at the Redlands Community College. Oklahoma City, Oklahoma, October 2-3, 2003.

Development and Utilization of Concept/Cognitive Maps in Nursing Education (podium presentation). All, A. C., Fisher, M. J., & Huycke, L. Faculty Inservice Day titled "Welcome Back & What's New?" at the OUHSC College of Nursing. Oklahoma City, Oklahoma. August 19, 2003

Nursing as a Profession (podium presentation). Part of the Summer Academy & Health Professions Presentations with high school students at The University of Oklahoma Health Sciences Center College of Nursing. June 9, 2003.

Are You Ready To Join The Healthcare Team? (podium presentation). Francis Tuttle Technology Center, Health Science Center Job and Career Fair. Oklahoma City, Oklahoma. April 17, 2003.

Developing and Utilization Concept/Cognitive Maps in Nursing Education (podium presentation). All, A. C. & Fisher, M. J. University of Oklahoma College of Nursing for nursing faculty at the Schusterman Center in Tulsa, Oklahoma. February 24, 2003.

Development and Utilization of Concept/Cognitive Mapping in Nursing Education. (podium presentation). All, A. C., Huycke, L., & Fisher, M. J. National League for Nursing Education Summit 2002: Engaging in Higher Education in Renewing the Nursing Profession. Anaheim, California, September 19-22, 2002.

Challenges in Practice: Medicaid Managed Care in Oklahoma (podium presentation). Fisher, M. J. & Huycke, L. Mayo Clinic's Quest for Quality Conference. Rochester, Minnesota, November 4-6, 2001.

Medicaid Managed Care in Oklahoma: The Basics (podium presentation). Family Perspectives Conference. Oklahoma City, Oklahoma, October 19-20, 2001.

Medicaid Managed Care in Oklahoma (podium presentation). Fisher, M. J. & Roberts, C. Oklahoma Parent's Center Conference. Oklahoma City, Oklahoma, September 2001.

Medicaid Managed Care, SoonerCare Health Education Partners and the Role of the Training Coordinator (podium presentation). People First: Norman Chapter monthly meeting. Norman, Oklahoma. July 24, 2001.

Interdisciplinary Training, Teaming, and Leadership in a World of Managed Care (podium presentation). All, A. C., Fried, J. H., & Fisher, M. J. University of Oklahoma Health Sciences Center, Graduate Research, Education, and Teaching (GREAT) Conference. Oklahoma City, Oklahoma, March 26-30, 2001.

Interdisciplinary Training, Teaming, and Leadership in a World of Managed Care (podium presentation). All, A. C., Fried, J. H., & Fisher, M. J. National Rehabilitation Association Annual Training Conference. Cleveland, Ohio, September 6-10, 2000.

Interdisciplinary Practice, Family-Centered Care and the Impact of Managed Care (podium presentation). All, A. C., Moss, J., Fried, J. H. & Fisher, M. J. National Rehabilitation Association Annual Training Conference. Cleveland, Ohio, September 6-10, 2000.

Adolescent and Adult Health Issues and Disabilities (podium presentation). First Annual Bridges Conference. Tulsa, Oklahoma, April 14, 2000.

Role of the DDSD RN: Where We Have Been, Where We Are and Where We Are Going (podium presentation). Fisher, M. J. & Clark, P. Developmental Disability Services Division State Nursing Conference. Oklahoma City, Oklahoma, October 19-22, 1999.

Lego Blocks, Tinker Toys and Interdisciplinary Teaming (podium presentation). All, A. C., Fisher, M. J., & Moss, J. Invited Speakers, American Association of Critical Care Nurses South Central Oklahoma Conference. Norman, Oklahoma, October 15-16, 1999.

Careers in Management (podium presentation). For the Office of Career Planning and Placement, The Career Management Association and the Society for the Advancement of Management at Bentley College Conference. Waltham, Massachusetts, February 18, 1987.

UNIVERSITY GOVERNANCE

University of Oklahoma Health Sciences Center (OUHSC)

2004 – Present	Faculty Representative, OUHSC Big Event, annual interdisciplinary student volunteer event in the Oklahoma City community
2010 – 2011	Elected member, OUHSC Faculty Compensation Committee

Spring 2006	Faculty Representative, OUHSC Student Awards selection committee

OUHSC College of Nursing

2012 – Present	Elected member, By-Laws Committee
2002 – Present	Appointed Faculty Advisor, Men's Caucus in Nursing
2010 – 2011	Appointed, Academic Misconduct Board
2004 – 2006	Selected and served as the Oklahoma City Campus Representative, BSN Curriculum Revision Steering Committee
2003 – 2004	Member, Dean's Student Advisory Council
2002 – 2004	Member, Curriculum Committee

PROFESSIONAL SERVICE

Service: Peer Review Activities

2006 – Present	Manuscript Reviewer for the *Journal of Pediatric Nursing*.
2006 – Present	Manuscript Reviewer for the *Pediatric Nursing*.
2004 – 2010	Manuscript Reviewer for the *Neonatal, Paediatric and Child Health Journal*.
2006	Reviewer for the 2005 Nursing Workforce Diversity (NWD) Grant Program. U.S. Department of Health & Human Services (HHS), Health Resources and Services Administration (HRSA). March 20-22, 2006 (Washington, D.C. review).
2006	Reviewer for the 2005 Nursing Education, Practice and Retention (NEPR) Grant Program. U.S. Department of Health & Human Services (HHS), Health Resources and Services Administration (HRSA). March 13-16, 2006 (Washington, D.C. review).

2005	Reviewer for the 2004 Nursing Education, Practice and Retention (NEPR) Grant Program. U.S. Department of Health & Human Services (HHS), Health Resources and Services Administration (HRSA). February-April 2005 (field review).
2005	Reviewer for the 2004 Nursing Workforce Diversity (NWD) Grant Program. U.S. Department of Health & Human Services (HHS), Health Resources and Services Administration (HRSA). February 15-18, 2005 (Washington, D.C. review).

Service: Community Activities

2007 – 2012	Board Member with Cavett Kids Foundation, LLC; Elected and currently serving as Secretary for January 2011 – December 2011. Involved in grant development (outcome evaluation), editing, and writing: Oklahoma City Community Foundation's (OCCF) Opportunities for Children iFUnd grant (funded) and OCCF's Sustainable Organization Support (SOS) grant (under review); served on hiring committee during search and hiring process for part-time employee to assist Executive Director.
2005 – 2009	Cavett Kids Foundation, LLC: Summer Camp 2008 volunteer. Camp counselor for boys and girls with life threatening illnesses. Served as a cabin counselor working with boys ten-twelve years old; Lake Texoma, Oklahoma July 7-12, 2009, July 8-13, 2008, Guthrie, Oklahoma, August 10-12, 2007, Lake Texoma, Oklahoma, July 13-18, 2006, and July 5-10, 2005.

Service: Other Activities

2001 – 2005	Sigma Theta Tau International; Elected and served as Member of Nominating Committee (2003-2005); elected and served as First Vice-President and Chair of Programs Committee (2001- 2003); served as President when elected and serving President vacated office prior to term completion (February 2002-April 2002).
October 2008	*Dream Course – Integrated Practice: Specializing in Healthcare* for undergraduate; University of Oklahoma architecture (ARCH 3554) and interior design (ID 4744) students; Served as a reviewer (also recruited a parent to serve as a reviewer) of student proposals for a new pediatric clinic in Duncan, Oklahoma, review process conducted in Norman, Oklahoma, October 8, 2008.

April 1999	Volunteer, Undergraduate Nursing Student Health Fair, The University of Oklahoma College of Nursing

PROFESSIONAL GROWTH AND DEVELOPMENT

2011	*The Simulation Pre-Conference* presented by the Oklahoma Health Care Workforce Center and the OU Clinical Skills Education and Testing Center and the *Fifth Annual Simulation Conference: A Best Practices Simulation Conference* presented by the Oklahoma Health Care Workforce Center, May 24 & 25, 2011. Oklahoma City, Oklahoma.
2009	*Midwestern Nursing Research Society 2009 Annual Research Conference*. Attended pediatric, newborn and family sessions and research meetings, research funding presentations, March 27-30, 2009. Minneapolis, Minnesota.
2008	*Midwestern Nursing Research Society 2008 Annual Research Conference*. Attended pediatric, newborn and family sessions and research meetings, research funding presentations. Served as a volunteer assisting in several areas during conference. March 29-31, 2008. Indianapolis, Indiana.
2007	*OUHSC College of Nursing Fall (3rd) Nursing Research Retreat*. Presented by Jana Pressler, Pamela Cedeno, Gary Parker, Susie Jones, Barbara Holtzclaw, Adrienne Blalock, and Sangeetha Tadmilla. November 13, 2007. Oklahoma City, Oklahoma.
2007	*Institute for Healthcare Improvement: Health Professions Education Collaborative Meeting*. "Charting the Future of Healthcare: Issues and Challenges of Inter-Professional Collaboration" by Daniel Evans; "Promoting Interprofessional Partnerships for Safety" by Betsy Lee; "World Café Discussions" with Rich Frankel and Steve Bodgewick; "Opportunities for Improvement: Using CQI & multidisciplinary Teams to Improve the Medical Home at the PCC" with Sarah Stelzner; "Appreciative Inquiry: Theory and Practice" with Dave Mossbarger. October 17-18, 2007. Indianapolis, Indiana.
2007	*OUHSC College of Nursing Second OU Nursing Research Retreat* presented by Kay Edwards, Jana Pressler, Kathy Dwyer, Barbara Holzclaw, Patsy Smith, Deb Wisniewski, Voncella McCleary-Jones, and Valerie Eschiti. April 20, 2007. Oklahoma City, Oklahoma.

2007	*Midwestern Nursing Research Society 2007 Annual Research Conference*. Attended pediatric, newborn and family sessions and research meetings, research funding presentations, and arranged an individual consultation with Kathleen Knafl – discussed dissertation research plans. March 23-26, 2007. Omaha, Nebraska.
2006	*Creating Interdisciplinary Cultures: Insights and Practices from Complexity Science and Relationship Centered Care Conference* presenters included Curt Lindberg, Tony Suchman, Brenda Zimmerman, Dan Pesut, Penny Williamson, Arvind Singhal, Keith McCandless, and Henri Lipmanowicz, November 18 and 19, 2006. Indianapolis, Indiana.
2006	*Complexity in Health Care Workshop*: "Application for Nurse Educators in the Curriculum" and "Application of Complexity Science for Health Care Organizations" and an individual consultation presented by Tom Clancy, October 13, 2006. Oklahoma City, Oklahoma.
2006	*OUHSC College of Nursing First OU Nursing Research Retreat Fall 2006* presented by Jana Pressler, Barbara Holtzclaw, Jo Azzarello, Lazelle Benefield, Barbara Skaggs, and Elena Cuaderes, November 3, 2006. Oklahoma City, Oklahoma.
2006	*The University of Oklahoma Health Sciences Center Educational Grand Rounds* "Virtual Worlds for Educating Healthcare Providers" presented by LeRoy Heinrichs (Stanford University), April 21, 2006. Oklahoma City, Oklahoma.
2006	*University of Oklahoma Medical Center Clinical Day* "Traditions and Transitions: Promoting A Positive Future For Nurses" presented by K. Lynn Wieck, February 9, 2006. Oklahoma City, Oklahoma.
2005	The University of Oklahoma Health Sciences Center (OUHSC) College of Nursing; Directed Readings (NURS 5960): Developed and submitted "One-Minute Paper" manuscript for publication – with Barbara Holtzclaw, PhD *(paper published 2006)* Oklahoma City, Oklahoma.
2004	The University of Oklahoma Norman, Oklahoma Quantitative Research Methods and Statistics (COMM 5003)

TEACHING ACTIVITIES

The University of Oklahoma Health Sciences Center College of Nursing
Generic or Traditional BSN – clinical

Years: 2011 – Present
Semester: Fall
Course Number: NURS 4026
Course title: Clinical III Nursing
Hours of instruction: 6 semester hours
Additional information: patient care areas: pediatric – intensive care, neonatal intensive care, hematology-oncology, and emergency care

Role: Clinical Instructor

Number of Students: 8-10 students in clinical group

The University of Oklahoma College of Medicine Department of Pediatrics
Graduate and Post Graduate – didactic and practicum

Years: 2010 – Present
Semester: Spring
Course Number: BMSC 5113
Course title: Interdisciplinary Leadership Issues I: Disability Services
Hours of instruction: 3 semester hours
Additional information: This course is part of the Oklahoma LEND long-term program for graduate, post-graduate, and professional students involving a minimum of 300 practicum hours

Role: Interdisciplinary Core Faculty in Nursing

Number of Students: 12-16 students from a variety of disciplines

The University of Oklahoma College of Medicine Department of Pediatrics
Graduate and Post Graduate – didactic and practicum

Year: 2010 – Present
Semester: Fall
Course Number: BMSC 5103
Course title: Interdisciplinary Leadership Issues I: Disability Services
Hours of instruction: 3 semester hours
Additional information: This course is part of the Oklahoma LEND long-term program for graduate, post-graduate, and professional students involving a minimum of 300 practicum hours

Role: Interdisciplinary Core Faculty in Nursing

Number of Students: 12-16 students from a variety of disciplines

The University of Oklahoma Health Sciences Center College of Nursing
Generic or Traditional BSN - clinical

Years: 2001 – 2011
Semester: Spring
Course Number: NURS 4136
Course title: Clinical Nursing IV
Hours of instruction: 6 semester hours
Additional information: patient care areas: pediatric – hematology-oncology, surgical, medical-surgical, emergency care, intensive care, neonatal intensive care, post-anesthesia care, and outpatient care

Role: Clinical Instructor and BSN prepared nurse preceptor coordinator for the Children's Hospital at OU Medical Center

Number of Students: 10-12 students in clinical group

The University of Oklahoma Health Sciences Center College of Nursing
Generic or Traditional BSN - clinical

Year: 2006 – 2010
Semester: Fall
Course Number: NURS 4020
Course title: Clinical III Nursing
Hours of instruction: 6 semester hours
Additional information: patient care areas: pediatric – intensive care, neonatal intensive care, hematology-oncology, and emergency care

Role: Clinical Instructor

Number of Students: 8-10 students in clinical group

The University of Oklahoma Health Sciences Center College of Nursing
Generic or Traditional BSN

2006 – Second OUHSC College of Nursing *Student Leadership Summit*. Mark J. Fisher and Jaye Hall, planned, organized, and delivered at the University of Oklahoma Health Sciences Center College of Nursing, Oklahoma City, Oklahoma, April 28, 2006.

The University of Oklahoma Health Sciences Center College of Nursing
Generic or Traditional BSN

2005 – First OUHSC College of Nursing *Student Leadership Summit*. Mark J. Fisher and Jaye Hall, planned, organized, and delivered at The University of Oklahoma Health Sciences Center College of Nursing, Oklahoma City, Oklahoma, August 19, 2005.

The University of Oklahoma Health Sciences Center College of Nursing
Generic or Traditional BSN – clinical

Year: 2001 – 2005 *Semester:* Fall *Course Number:* NURS 3025 *Course title:* Clinical Nursing I *Hours of instruction:* 5 semester hours *Additional information:* patient care area: adult medical-surgical	*Role:* Clinical Instructor; Course Coordinator (2002-2004); Course Co-Coordinator (2005)	*Number of Students: 8 students in clinical group; 115-125 students in course*

The University of Oklahoma Health Sciences Center College of Nursing
Generic or Traditional BSN – didactic/non-clinical

Year: 2001 - present *Semester:* Spring *Course Number:* NURS 4134 *Course title:* The Practice of Leadership *Hours of instruction:* 4 semester hours	*Role:* Instructor (2005 - present); Course Coordinator (2002-2005)	*Number of Students:* 115-125 students

The University of Oklahoma Health Sciences Center College of Allied Health
Graduate – didactic (seminar format)

Year: 2005 *Semester:* Spring/Summer *Course title:* Interdisciplinary Seminar *Hours of instruction:* 3 semester hours *Additional information:* Pilot project in an effort to offer course for students in any of the disciplines on the OUHSC campus	*Role:* Core Faculty	*Number of Students:* 6 students representing four different disciplines

The University of Oklahoma Health Sciences Center College of Nursing
Graduate – didactic/non-clinical

September/October 2004. *Interdisciplinary Practice* Guest Lecture and on-line discussion for graduate Clinical Nurse Specialist Systems Management students. The University of Oklahoma Health Sciences Center College of Nursing, September 27, 2004 – October 5, 2004.

The University of Oklahoma Health Sciences Center College of Nursing
Accelerated BSN – clinical

Year: 2004 *Semester:* Summer *Course Number:* NURS 4136A *Course title:* Clinical IVA *Hours of instruction:* 6 semester hours *Additional information:* Inaugural year for OUHSC College of Nursing Accelerated BSN Program	*Role:* Course Coordinator and Clinical Instructor	*Number of Students:* 8 students in clinical group; 16 students in course

The University of Oklahoma Health Sciences Center College of Nursing
Accelerated BSN – didactic/non-clinical

Year: 2004 *Semester:* Summer *Course Number:* NURS 4134A *Course title:* The Practice of Leadership *Hours of instruction:* 4 semester hours *Additional information:* Inaugural year for OUHSC College of Nursing Accelerated BSN Program	*Role:* Course Coordinator	*Number of Students:* 16 students

The University of Oklahoma Health Sciences Center College of Nursing
Accelerated BSN – clinical

Year: 2003 *Semester:* Summer *Course Number:* NURS 3125A *Course title:* Clinical IA *Hours of instruction:* 5 semester hours *Additional information:* Inaugural year and inaugural semester for OUHSC College of Nursing Accelerated BSN Program	*Role: Course Coordinator and Clinical Instructor*	*Number of Students:* 8 students in clinical group; 16 students in course

The University of Oklahoma Health Sciences Center College of Nursing
Graduate – didactic/non-clinical

February/March 2003. *Interdisciplinary Practice.* Guest Lecture and on-line discussion for graduate Clinical Nurse Specialist Systems Management students. University of Oklahoma Health Sciences Center College of Nursing, February 26, 2003 – March 11, 2003.

The University of Oklahoma Health Sciences Center College of Nursing
Graduate – didactic/non-clinical

October 2002. *Interdisciplinary Practice.* Guest Lecture and on-line discussion for graduate Clinical Nurse Specialist Systems Management students. The University of Oklahoma Health Sciences Center College of Nursing, October 3, 2002 – October 20, 2002.

The University of Oklahoma Health Sciences Center College of Nursing
Graduate – didactic/non-clinical

February/March 2002. *Interdisciplinary practice.* Guest Lecture and on-line discussion for graduate Clinical Nurse Specialist Systems Management students. University of Oklahoma Health Sciences Center College of Nursing, February 16, 2002 – March 3, 2002.