

BEYOND HEARING: NURSES' ACTIVE EMPATHETIC LISTENING BEHAVIORS  
FROM THE VOICE OF THE PATIENT

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## ABSTRACT

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### BEYOND HEARING: NURSES' ACTIVE EMPATHETIC LISTENING BEHAVIORS FROM THE VOICE OF THE PATIENT

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The purpose of this study was to distinguish between effective and ineffective nurse active empathetic listening (AEL) behaviors as perceived by adult inpatients from an acute care hospital. Nurse communication and more specifically, nurse listening is at the core of nurse-patient interaction and influences quality, safety, and patient experience. Nurse listening from the patient's perspective is poorly understood with a large gap in nursing science. A non-experimental two-group comparison descriptive study was conducted to determine if there was a difference in AEL behaviors as perceived by patients for nurses who listened ( $n = 194$ ) and those who did not ( $n = 50$ ). The two groups were identified based on the response to an initial filter question. A total of 244 medical and surgical patients responded to survey instruments (biographical data form; AEL survey) sent either to their home address or via email at a minimum of 15 days post discharge from a large acute care facility. No statistical difference was found between the demographics of the two groups. An independent  $t$ -test ( $\alpha = .05$ ) revealed a statistically significant difference in the two groups' perception of listening behaviors for those who listened and those who did not based on total score, subscales (sensing,

processing, and responding), and each of 11 AEL items. The AEL behavior most frequently identified by all participants as most important to them as a patient was “My nurses understood how I felt.” The Cronbach’s alpha calculated for the AEL scale’s total score and subscales exhibited strong reliability.

In conclusion, the findings of this study begin to narrow the gap in nursing science related to nurse listening behaviors from the perspective of the patient. Through a better understanding of nurse listening, practice changes can be implemented to impact quality, safety, and the patient experience.

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## CHAPTER I

### INTRODUCTION

Communication is essential to the establishment of relationships and all interactions among people; it is defined as a “process by which information is exchanged between individuals through a common system of symbols, signs, or behavior” (Merriam-Webster, 2018). The Business Dictionary (2018) describes communication as a two-way process where mutual understanding is reached where participants exchange (encode-decode) information and feelings while creating and sharing meaning. The earliest forms of communication in the Stone Age were symbols painted on the walls of caves. Fast forward to current times, communication through symbols in the Stone Age is similar to emojis in smart phone messaging. The communication process includes a sender and receiver (Nordquist, 2018) or speaker and listener.

Brownell (2010) has noted that, traditionally, the focus of communication has focused on the speaker and the message itself, rather than the receiver’s reception of the message. According to Wolvin (2010), listening is a complex human behavior and scholars continue to make progress in understanding its complexity. The International Listening Association defines listening as “the process of receiving, constructing meaning from, and responding to spoken and/or nonverbal messages” (Wolvin, 2010, p. 9).



“Most people do not listen with the intent to understand; they listen with the intent to reply,” states Stephen Covey (1989, p. 239). Covey referred to the human process of filtering what is heard and referencing personal life experiences, and forming a response before the speaker has completed their message. In a qualitative study of older adults in a long-term care setting, Jonas-Simpson, Mitchell, Fisher, Jones and Linscott (2006) focused on the experience of being listened to. The researchers identified the importance of being listened to and the impact on the quality of the resident’s lives, feelings of contentment, genuine vital connection, and potential to reduce suffering associated with not being listened to (Jonas-Simpson et al., 2006). Assuming the lived experiences of the listener are consistent with those of the speaker is inappropriate and disruptive to effective listening. Beyond hearing the message, effective listening is getting to the meaning of what is said (Ramsey & Sohi, 1997).

The nurse-patient relationship is guided by communication, both verbal and non-verbal, that is essential to achieving positive health outcomes. Fundamental to the relationship and communication is that patients are the expert about themselves (Reardon, 2009); therefore, it is essential that the healthcare team, and more specifically the nurse, understand patients’ needs through listening. In an article focused on perspectives of listening, Kagan (2008) explored the theoretical and research literature on the phenomenon of listening as it relates to different disciplines. For nursing, listening as a topic has been scarcely examined or published in nursing research literature despite being a basic element in nursing practice (Kagan, 2008). This finding remains consistent with

the results of the literature review conducted for this study. Wolf (2013) acknowledged that those who work in health care have diligently approached the patient experience from their own perspective and not that of the patient, who should be a partner in the care experience.

Effective communication is essential to the nurse-patient relationship, the achievement of quality health outcomes, and ultimately for the healthcare institution, to financial performance through reimbursement associated with metrics designed to evaluate overall patient satisfaction with the healthcare experience. Nurse communication is measured from the patient's perception of their experience with the nurse listening to them throughout their hospitalization. To better understand the patient's perception of nurse listening, the concept of listening needs to be better understood through attributes, behaviors, and characteristics that define it from the patient's perspective. Narrowing the gap in nursing science related to listening from a practice and educational perspective is important to enhance patient experience, safety and health outcomes.

### **Problem of Study**

The identification of effective listening behaviors and characteristics perceived by the patient will guide changes in nursing practice and education. Therefore, an initial step to enhancing the communication skills in the nurse-patient relationship is essential to patient satisfaction, quality and safety is through research. The aim of this study is to

distinguish between effective and ineffective nurse active empathetic listening behaviors as perceived by adult inpatients from an acute care hospital.

### **Rationale**

Communication, more specifically listening, has not been a focus of research from the speaker's perspective but plays an important role in patient experience, quality and safety outcomes. With the shift from volume to value, hospitals are being financially penalized for failing to achieve targeted measures as part of the Value Based Purchasing (VBP) program. From a patient experience perspective, 2% of Medicare payments are withheld from hospitals that perform poorly on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. In 2017, \$1.7 billion in Medicare payments will be held back from hospitals based on results from HCAHPS (Becker's Hospital Review, 2017). Based on Press Ganey's research, hospitals focusing on the nurse communication metric would potentially influence 15% of their VBP incentive payment (Rodak, 2013). The specific HCAHPS survey questions (AHRQ, 2018) related to nurse communication are:

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
2. During this hospital stay, how often did nurses listen carefully to you?
3. During this hospital stay, how often did nurses explain things in a way you could understand?

Press Ganey conducted research using a hierarchical variable clustering analysis of all eight HCAHPS dimensions (Press Ganey, 2013). Five of the eight dimensions clustered together with nurse communication being the dominant dimension. The findings from this analysis indicated that it is probable that improvements would occur in the four other cluster dimensions (responsiveness of hospital staff, pain management, communication about medication, and overall rating) if hospitals focused on improving the nurse communication dimension. Hospital's prioritization of nurse communication strategies will potentially have positive impacts beyond VBP (Press Ganey, 2013). Effective communication and listening skills are necessary for nursing practice and further emphasized through the financial impact if not demonstrated well from the patient's experience.

The impact of communication on quality and safety was recognized by the Institute of Medicine (IOM) in two landmark reports. The report *To Err is Human: Building a Safer Health System* (Kohn, Corrigan, & Donaldson, 2000) drew public attention to quality concerns in the health care system related to patient safety. The National Patient Safety Foundation (NPSF) convened an expert panel fifteen years later to evaluate progress made through actions taken to make care safer for patients. Their report, *Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after to Err is Human*, outlines remaining gaps, progress, and recommendations to accelerate progress (NPSF, 2015). One recommendation was "Partner with patient and families for the safest care" (NPSF, 2015, p. 31). One of the tactics recommended to ensure safer

care was the provision of communication training for health care workers with effective listening as one of the critical elements. This tactic emphasized the need to concentrate efforts on communication and listening to enhance patient safety. Chou (2018) acknowledged that communication skill training is not the solution for all problems, but can reliably improve patient experience, outcomes, and quality.

In 2001, the IOM published *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century* a second report of the Committee on the Quality of Health Care in America. Redesigning the healthcare system to innovate and improve care was the focus of the report. Patient-centered care was one of the key dimensions identified for improvement. In this report (IOM, 2001, p. 6), patient centered care was defined as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decision.” Through effective communication and listening to the patient to understand their individual needs, patient centered care can be realized to provide high-quality care.

In a series of papers focused on patient experience, Wolf (2013) identified the ability of healthcare workers to listen to both the spoken and unspoken words of the voices involved in the patient care experience as a common theme and crucial to their role as providers. In the field of communication studies, listening scholars recognize the need to develop models of listening competence (Bodie, 2013). Bodie (2013) acknowledged that understanding the specific behaviors that constitute “good listening”

and their relationship to important outcomes provides the fuel for continued research focused on this fundamentally important communication skill.

Despite the recognized importance and impact on patient experience, quality outcomes, and reimbursement, research related to nurse communication from the patient's perspective is very limited. Based on a thorough literature review, the majority of research in nursing science on the topic of listening focused on listening from the nurses' perspective.

For hospitals to improve on these performance measures, they must seek to better understand the patient's expectations and make the necessary changes when these expectations do not align with the reality of their experiences with the healthcare organization. Through identification of perceived listening behaviors, focused interventions can be put in place with the goal of more closely aligning the patients' expectations with reality, which will ultimately elevate the patient's assessment of the hospital experience, and optimally, achievement of improved health outcomes.

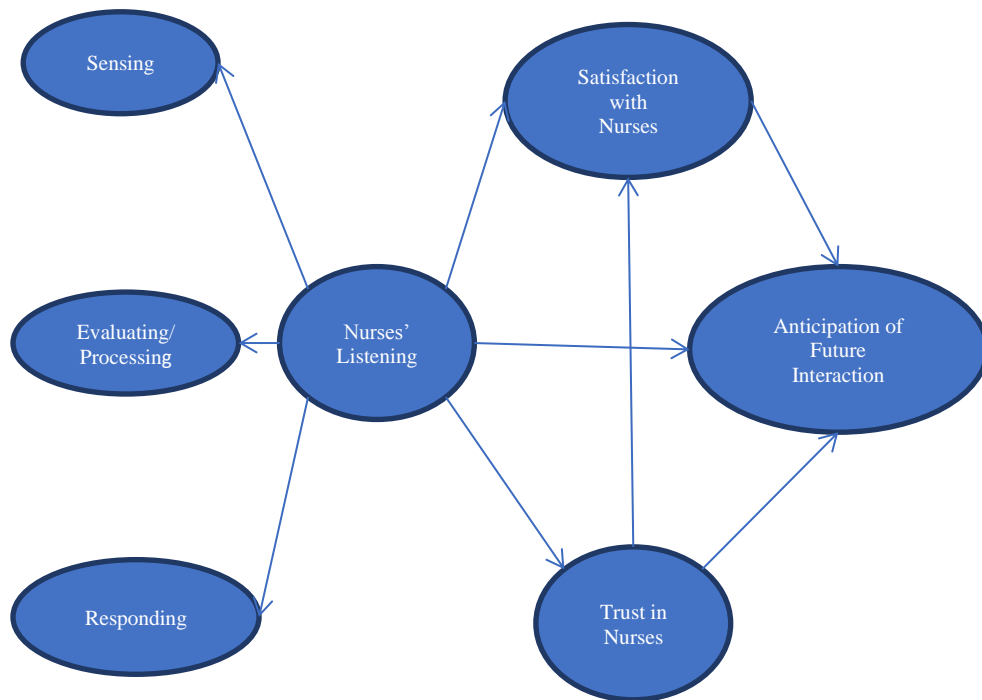
With effective communication skills being pivotal to nursing practice and patient interactions, narrowing the gap in nursing science related to listening from a practice and educational perspective is important. Despite the identified need to improve nurse-patient communication, insufficient nursing research has been conducted to identify interventions to transform practice (Edwards, Peterson & Davies, 2006).

## **Conceptual Framework**

The conceptual model developed by Ramsey and Sohi (1997), which addressed salesperson listening behaviors on customer relationship outcomes, provides the framework for this study (see Figure 1). Listening was described as consisting of three dimensions and is depicted in the conceptual model as sensing, interpreting (also noted as processing in similar models), and responding. Based on the model, the authors acknowledged that these components work together to produce a higher-order listening construct. Ramsey and Sohi's (1997) conceptual model also demonstrated the impact of salesperson listening on trust, satisfaction, and anticipated future interactions. The entirety of this conceptual model aligns with the needs and rationale for this study to improve patient satisfaction in the healthcare setting through better understanding of effective listening behaviors. For the purpose of this study, Ramsey and Sohi's model (1997) was adapted for nurse communication by replacing the role "salesperson" with "nurses."

In 1999, Comer and Drollinger defined the three listening dimensions, demonstrated empirically by Ramsey and Sohi when focusing on salespeople's listening, and introduced active, empathetic listening in this context. The first dimension, "sensing," is the physical receipt of both verbal and non-verbal information from the speaker. "Processing" is the second dimension where the receiver of the information cognitively processes through understanding, interpreting, evaluating and remembering. Comer and Drollinger (1999) described the last dimension, "responding," as

demonstrating both verbally and non-verbally to the speaker, assuring listening has occurred. The three dimensions occur almost simultaneously but must follow the sequence of sensing, processing, and responding (Comer & Drollinger, 1999).



*Figure 1.* Conceptual Model for Active Empathetic Listening  
Adapted from Ramsey & Sohi (1997, p. 128)

Drollinger, Comer, and Warrington (2006) used the model created by Ramsey and Sohi to create the Active Empathetic Listening (AEL) scale. Consistent with Ramsey and Sohi's model, AEL is conceptualized as having three dimensions identified as sensing, interpreting, and responding reflected in the items on the scale. According to Drollinger et al. (2006), "sensing" is the most basic listening dimension and includes not only hearing the words spoken but receiving non-verbal implied messages through body



language and expressions. “Processing” is the component of listening that involves the cognitive processing of the listener where messages are categorized, converted to meaningful and usable forms, and remembering by updating memory. The third dimension, “responding,” refers to the signals that the listener returns to the speaker to signify their message has been heard. These definitions developed by Drollinger et al. (2006) for the active empathetic listening processes associated with Ramsey and Sohi’s conceptual model will be used for this study focused on nurse listening.

### **Assumptions**

The following assumptions, relevant to this study, are derived from Ramsey and Sohi’s (1997) hypothesized relationships between the constructs of their conceptual model:

- Perceived listening behavior is composed of three dimensions: sensing, evaluating/processing, and responding.
- There is a positive association between customer’s (patient’s) perception of listening behavior and their trust.
- There is a positive association between customer’s (patient’s) perceptions of listening behavior and their satisfaction.
- There is a positive association between customer’s (patient’s) perceptions of listening behavior and anticipated future interaction.
- There is a positive relationship between customer’s (patient’s) trust and satisfaction.

- There is a positive relationship between customer's (patient's) trust and anticipated future interaction.
- There is a positive relationship between customer's (patient's) satisfaction and anticipated future interaction.

It is believed that the above stated assumptions associated with salesperson listening behaviors and their customers are consistent with nurse listening behaviors and their patients.

### **Research Questions**

The design for this quantitative study was non-experimental and explored the following research questions:

1. Do patients admitted to an acute care hospital perceive a difference between nurses who exhibit active empathetic listening behaviors and those who do not?
2. Is there a difference in the demographics of patients who perceive that nurses employ active empathetic listening behaviors versus those nurses who do not?
3. Which of the characteristics of active empathetic listening behaviors are perceived by the patients as most important?

### **Definition of Terms**

The following terms were defined for this study:

Active empathetic listening: a process whereby the listener receives verbal and non-verbal messages, processes them cognitively, responds to them verbally and non-

verbally, and attempts to assess their underlying meaning intuitively by putting themselves in the customer's place (Comer & Drollinger, 1999, p. 18).

Acute care hospital: a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition; U.S. Centers for Medicare & Medicaid Services, n.d.).

Nurses: registered nurses who care for patients on medical and surgical acute care units.

Patients: individuals admitted to an acute care hospital.

### **Limitations**

The descriptive study design and the use of a convenience sample from only one acute care hospital limits the generalizability of the findings from this study. The conclusions are therefore limited to the patient population and setting studied.

### **Summary**

The establishment of a positive nurse-patient relationship is dependent on effective nurse communication including listening skills. Listening is an important element of the interaction between the nurse and patient in the delivery of care. Based on the literature reviewed for this study, there was an absence of published research in nursing science on this topic. With the dearth of empirical evidence, nursing practice related to listening is based on assumptions and not the patient's reality. The goal of this study was to identify the effective and ineffective observable behaviors of the nurse that

patients associate with being listened to. The findings from this study may provide feedback for nurses to modify their behavior(s) to become better listeners.

## CHAPTER II

### REVIEW OF LITERATURE

This chapter contains a manuscript that has been submitted for publication in *Nursing Economic\$*.

Not Listening Could Co\$t You

#### **Introduction**

Nurses spend more time with patients than any other health care professional and most often serve as the major conduit of information between the patient and other health care providers. Thus, nurses must be good communicators. Nurse communication, and more specifically nurse listening, is assessed by the perception of the patient's experience with the nurse listening to them. Listening carefully is at the core of nursing practice and is a key element of patient experience and safety (Balik & Dopkiss, 2010). Despite the recognized importance and impact on patient experience, quality outcomes, and reimbursement, there is an absence of research on effective nurse communication from the patient's perspective. On the basis of a literature review, there is limited research in nursing science on the topic of listening, and the majority of the articles discuss listening from the perspective of the nurse.

Healthcare's shift from volume to value requires hospitals to focus on outcomes, such as patient experience, as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The survey found that nursing

communication has the greatest impact on the patient’s overall experience score (Studer Group, 2012). The first series of HCAHPS survey questions focuses on “your care from nurses” (AHRQ, 2018, p. 1):

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
2. During this hospital stay, how often did nurses listen carefully to you?
3. During this hospital stay, how often did nurses explain things in a way you could understand?

In fiscal year (FY) 2015, the Value-Based Purchasing (VBP) program affected 1.5% of the base operating payments in hospitals, at an estimated amount of \$1.4 billion (Elliott et al., 2016). The impact increased to 2.0% in FY 2017 and is projected to remain at this percentage through FY 2019. In 2017, \$1.7 billion in Medicare payments will be withheld from hospitals with poor performance on the HCAHPS survey (Becker’s Hospital Review, 2017). According to Press Ganey’s research findings, hospitals focusing on improving the nurse communication metric could potentially impact 15% of their incentive payment associated with VBP (Rodak, 2013).

Using data from 3,062 acute care hospitals in the United States, Press Ganey (2013) conducted a hierarchical variable clustering analysis on all eight HCAHPS dimensions. Press Ganey (2013) describes the variable clustering analysis as the identification of multiple measures that “hang together” consistently, while the hierarchical analysis identifies the measure that leads the others in the cluster. Five of the

eight dimensions are consistently clustered with nurse communication, which is also the dominant dimension. On the basis of this analysis, it is probable that the other four dimensions in the cluster (responsiveness of hospital staff, pain management, communication about medication, and overall rating) would experience an improvement in performance if hospitals focused on improving the nurse communication dimension. Identified as the “rising tide” measure, the findings of this study support hospital prioritization of strategies focused on improving nursing communication, with potential positive impacts beyond VBP (Press Ganey, 2013).

### **Aim**

The aim of this article is to identify and synthesize published research on behaviors associated with effective listening as perceived by the speaker (patient).

### **Methods**

The methods used for this integrated literature review included a search of published research studies supporting the identification of perceived behaviors associated with effective listening from the speaker’s (patient’s) perspective. The databases that were searched included the Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PubMed, and Communication & Mass Media Complete, using the keywords/phrases *nurse listening*, *active empathetic listening*, *active listening*, and *empathetic listening* and limiting the date search interval from 2006 to 2017. Consistent with the focus of this review, the ProQuest Dissertations & Theses database (Nursing and Allied Health; Business) was searched for the keywords *nurse listening* and *active*

*empathetic listening* and with the same date search interval. Additional articles for this review were identified from reference lists within relevant articles and from a review of articles authored by Bodie, a notable communication scholar and writer on the topic of listening. Inclusion criteria for this review were original, full-text research studies published in English, with listening as an element of the communication process and the sample drawn from an adult population. Exclusion criteria included communication studies that were not focused on listening behaviors perceived by the sender (speaker).

## **Results**

This literature search was undertaken in December 2017 and produced 1,137 articles prior to the removal of duplicate articles ( $n = 232$ ). After screening the titles and the abstracts for alignment with the inclusion and exclusion criteria, 13 studies remained for more detailed, full-text review. After final review of the 13 articles, four articles comprising five studies (one article included two studies) were relevant to the aim of this paper and were included in the data synthesis (see Figure 2.1).

The five studies reviewed for this article consist of two quantitative and two qualitative studies, and one dissertation (qualitative), with publication dates ranging from 2000 through 2012. Participants in the three qualitative studies were patients/clients, whereas collegiate communication students served as participants in the remaining two quantitative studies (see Table 2.1).

Of the three qualitative studies reviewed, two were conducted in Canada (Jonas-Simpson, Mitchell, Fisher, Jones & Linscott, 2006; Myers, 2000); the qualitative



dissertation by Clementi (2006) was conducted in the United States. These studies were not from a hospital setting but focused on the patient's/client's viewpoint of being listened to. The sites for these three studies were diverse and represented a heart failure clinic, long-term care center, and university counseling center. The sampling methodology for the three qualitative studies varied. One study (Jonas-Simpson et al., 2006) used volunteer participants, with a sample size of 19. The approach taken by Myers (2000) was discriminate sampling, yielding only five volunteer participants, and Clementi (2006) had a convenience sample of 18 participants. The age of participants were reported as follows: greater than 25 years (Myers, 2000), 70 to 90 years (Jonas-Simpson et al., 2006), and average age of 65 years (Clementi, 2006). The methodology used for data collection varied from open-ended phenomenological interviews and written narratives (Myers, 2000) to semi-structured interviews with open-ended questions (Jonas-Simpson et al, 2006; Clementi, 2006). The findings are consistent across all three studies—the feeling of being listened to is gratifying. The common, observable trait associated with listening identified in the qualitative studies was the facial expression of the caregiver during caregiver-patient dialogue. The visible facial emotional expression observed by the patient/client was consistent with what was being said such as not smiling when an unpleasant story was being told (Jonas-Simpson et al., 2006) or not flinching when something painful was discussed (Myers, 2000). There was a consensus among the researchers that future studies must be conducted to focus on the

patient's/client's experience of being listened to as part of the relationship, in order to enhance practice.

The two quantitative studies included in this synthesis were conducted in an academic setting in the United States, with students enrolled in communication studies as the participants. These studies, performed by Bodie, St. Cyr, Pence, Rold, and Honeycutt (2012), build on an empirical database of attributes and behaviors related to effective listening during an initial interaction. The initial Bodie et al. study included 352 participants with an average age of 20.44 years, while 150 students with an average age of 20.29 years participated in the second study. These studies by Bodie et al. (2012) were focused on initial interactions and perceived attributes (what competent listening is) and behaviors (what competent listeners do). In the first study (Study #1), participants were asked to list characteristics (limited to 20) of an initial encounter that led them to perceive the other individual as a competent communicator. Subsequent to this line of inquiry, the participants were asked to rate the degree to which the identified characteristics were associated with the perception of good listening. Bodie et al. (2012) acknowledged a limitation of the study was that the researcher determined the relationship of the categories to listening competence, but the initial responses prior to categorization were related to listening competence of the listener, as perceived and reported by the participants.

Participants in the second quantitative study (Study #2; Bodie et al., 2012) were randomly assigned to one of the following six conditions to list behaviors that would lead

them to believe someone was: understanding, a good listener, responsive, paying attention, enabling conversational flow, or friendly. Once the behavioral characteristics were identified, the participant was prompted to rate how a specific characteristic related to listening competence (1 = *definitely a characteristic of listening competence*; 6 = *definitely not*). The results are presented in Table 2.1. The second part of this study was not included in this review as it provided participants with the list of categories from the first study; therefore, it did not collect original perceptions of listening attributes and/or behaviors from the speaker's perspective.

The behaviors identified in the five studies included in this review are summarized in Table 2.2. The common themes across the qualitative and quantitative studies are grouped into verbal and non-verbal responses that indicate the listener was perceived by the speaker to be listening. The non-verbal responses included body language characterized as eye contact, head nod, body position, facial expressions/emotions, and smiling. The verbal behaviors most commonly cited were the use of questions and subject/content-appropriate responses.

## **Discussion**

The patient's perception of the quality of nurse listening has an important impact on their overall hospital experience and affects hospital reimbursement. Considering the importance of listening from the patient's perspective, as measured by HCAHPS, it is time we examine the impressions of listening behaviors from the viewpoint of

hospitalized patients. The studies included in this integrated review did not focus on the patient's experience in an acute care setting.

Nursing science content regarding the concept of listening and its definition within the nurse-patient interaction/relationship, from the patient's viewpoint, is essentially absent. The majority of the articles identified during an initial search focused on listening from the perspective of the nurse. "Most authors have been concerned with the perspective of professional therapists, physicians, or nurses and their perceptions and feelings as listeners, not with the perspective of the one feeling listened to," states Kagan (2008, p. 105). The initial targeted literature search conducted yielded limited nursing science results related to the aim of this review; therefore, the search was expanded to include other healthcare settings and disciplines.

While limited in nursing science, research with a focus on listening from the speaker's perspective has been an area of interest in the sales and communication industries. Ramsey and Sohi (1997) developed a conceptual model to address salesperson listening behaviors on customer relationship outcomes. In their work, listening is described as consisting of three dimensions and is depicted in the conceptual model as sensing, interpreting (also noted as processing in similar models), and responding. On the basis of the model, the authors acknowledge that these components work together to produce a higher-order listening construct. The conceptual model of Ramsey and Sohi (1997) also demonstrates the impact of salesperson listening on trust, satisfaction, and anticipated future interactions (see Figure 2.2). The conceptual model

can be adapted to similarly reflect the patient's perceived behaviors of the nurse, categorized by sensing, processing, and responding, and their relationship to nurse listening, resulting in patient satisfaction and trust in the healthcare setting and future interactions.

Comer and Drollinger (1999) introduced active empathetic listening (AEL) as a higher form of listening. The authors defined AEL as “a process whereby the listener: receives verbal and non-verbal messages, processes them cognitively, responds to them verbally and non-verbally, and attempts to assess their underlying meaning intuitively by putting themselves in the customers' place” (Comer & Drollinger, 1999, p. 18). The conceptual model, AEL dimensions, and associated relationship outcomes developed for salespeople align with the level of listening needed in the nurse-patient relationship to produce similar customer (patient) satisfaction and trust.

Beyond patient experience, the impact of communication on patient quality and safety was recognized by the Institute of Medicine (IOM) in two landmark reports. The report “*To Err is Human: Building a Safer Health System*” (Kohn, Corrigan, & Donaldson, 2000) focused on specific quality concerns related to patient safety, drawing public attention to the need for a safer health care system. Fifteen years later, an expert panel, convened by the National Patient Safety Foundation (NPSF), reviewed the improvements demonstrated as a result of the IOM call to action to make care safer for patients. Their report, “*Free from Harm: Accelerating Patient Safety Improvement Fifteen Years After To Err Is Human,*” outlines areas of progress, identifies remaining

gaps, and provides recommendations to accelerate progress (NPSF, 2015). One of the recommendations relevant to the aim of this manuscript is “Partner with patients and families for the safest care” (NPSF, 2015, p. 31). One of the tactics to achieve this recommendation is to “provide communication training for health care workers that include concepts of shared decision making, cultural sensitivity, language literacy, *effective listening* and respect in personal interactions” (NPSF, 2015, p. 31). This tactic further substantiates the need to focus on communication to enhance patient safety.

In 2001, the IOM published a second report of the Committee on Quality of Health Care in America entitled *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*. The report focused on redesigning the health care system to innovate and improve care. The committee set forth six aims for improvement to address the following key dimensions: health care should be safe, effective, patient-centered, timely, efficient, and equitable (IOM, 2001). This report defines, patient-centered care as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (IOM, 2001, p. 6). The Committee on Quality of Health Care in America recognized the impact effective methods of communication between patients and their caregivers as well as among the patient care team have on the provision of high-quality care.

The Committee on Quality of Health Care in America called upon the Agency for Healthcare Research and Quality (AHRQ) to work with stakeholders to develop strategies, goals, and action plans to achieve the identified six aims. From the IOM

framework, AHRQ's focus on patient-centered care produced the *Guide to Patient and Family Engagement in Hospital Quality and Safety* (AHRQ, 2017). Within the guide are strategies focused on communicating to improve quality, emphasizing its foundational impact on partnerships between patient, family, and clinicians. Communication is a critical component of high-quality and safe care, and if effective, can improve patient outcome, safety, and perceptions of quality (AHRQ, 2017). Listening is an important aspect of communication; understanding how to enhance caregiver skills will promote patient-centered care and further elevate quality and safety performance along with patient experience.

The identification of listening behaviors and characteristics that are gratifying to the patient will guide changes in nursing practice and education. Therefore, defining attributes for effective nurse listening, as perceived by the patient in the nurse-patient relationship, and confirming them through research will be a first step toward enhancing this pivotal communication skill that is critical to patient satisfaction, outcomes, and safety. The patient's perception that the nurse always listens carefully is evidence of patient-centered care.

Based on the results of the studies reviewed, non-verbal communication such as eye contact and body language were findings that signified to the patient/client/speaker that the recipient of their message was listening. With the increasing use of electronic health records (EHRs) as part of the Centers for Medicare & Medicaid Services (CMS) EHR incentive program known as Meaningful Use (U.S. Department of Health and

Human Services for Medicare and Medicaid Services, 2017), hospitals have invested in more mobile computers to make access for the caregivers more efficient and timely. These mobile computers or computers mounted on walls within the patient care room may be impacting the patient's experience, such as reducing eye contact and body language when caregivers are positioned at the keyboards, sometimes hidden behind the mobile computer, perusing clinical information and entering data provided by the patient. The studies reviewed for this article were published prior to the 2011 initial implementation of Meaningful Use; therefore, the impact on the experience of caregiver listening may not be reflected in those studies. The evolution of computers in the patient care space is only one example of a potential environmental impact that is different from the cited study locations that may influence the results found by the authors. We need to take what we have learned from the authors and explore listening in the hospital setting to address the needs of our patients and understand their expectations to enhance the patient experience.

In the fast-paced hospital environment, it is essential to understand our patient's need for the delivery of quality care and respect for their individual needs. Through this integrated review, it is evident that there is an absence of scientific evidence to support interventions that will enhance our patient's experience of being *listened to*.

Communication is fundamental to relationships and is even more critical in a healthcare setting encircled with uncertainty and lack of familiarity for the patient. The listening skills of the healthcare team, and more specifically the nurse, must be refined to meet our



patient's expectations to provide the quality outcomes they deserve. Quality is the highest priority, but if not achieved as evidenced by VBP, hospitals will experience a negative financial impact to their bottom line.

### **Implications for future research**

As stated by van Dulmen (2017, p. 1975), "Listening is at the very heart of communication in healthcare, but largely ignored in research and teaching." It is evident, based on this integrated literature review, that the need to focus on listening as a fundamental communication skill in nurse-patient interactions is essential.

With communication as a cornerstone of nursing practice and patient interactions, narrowing the gap in nursing science related to nursing practice and education is imperative. The gap in knowledge not only impacts the bedside practice of the nurse, but it also does not inform nursing educators regarding the communication behaviors related to the art of listening. If the results from the HCAHPS survey indicate the patient's dissatisfaction with the nurse's listening behaviors, appropriate interventions should be implemented. With the lack of nursing science to understand the patient expectations, the action plan developed to increase satisfaction is based only on assumptions. Despite the identified need to improve nurse-patient communication, insufficient nursing research has been conducted to evaluate interventions to transform practice (Edwards, Peterson & Davies, 2006). It is incumbent upon the profession to narrow this gap in nursing science to demonstrate our commitment to patient experience, safety, and health outcomes.

This integrated literature review calls attention to the reality that nursing science does not provide direction on the fundamental communication skill of listening to our patients in a manner that reassures them that the nurse is actively listening to them. Due to the lack of research in this area and its importance in the nurse-patient relationship, the need to study this topic is paramount. Bodie (2013) emphasizes that listening is a critical element of communication, with significance across the life span. He acknowledges the work done by communication scholars, focused on individual listeners and components of the process, but points out that “much less is known about the specific behaviors that constitute ‘good listening’ and their connection to important outcomes” (Bodie, 2013, p. 81). It is through researching the behaviors perceived to represent good listeners that will help guide the practices associated with the nurse-patient relationship to meet the patient’s expectations.

Shiple (2010) concluded in her concept analysis of listening that few tools exist to measure listening. The tools that were identified in nursing research did not include the nurse’s listening skills from the patient perspective, underscoring the lack of attention to the patient’s viewpoint (Shiple, 2010). Of all the articles reviewed for this integrated review, none represented the inpatient perspective of nurse listening skills from the patient’s viewpoint. As noted earlier, the AEL scale was created by Drollinger, Comer, and Warrington (2006) for salespersons for the purpose of eliciting feedback from the customer. The AEL scale was validated by Bodie (2011) for use outside of sales to report perceived behaviors of good or bad listening. The use of the AEL scale should be

investigated to close the gap in nursing science associated with perceived effective listening behaviors from the patient's perspective in the inpatient setting.

### **Conclusion**

Good nurse communication, including listening skills, is essential to the establishment of a positive nurse-patient relationship. The act of listening is an important component of the interaction between the nurse and patient in the care delivery process. Based on the literature reviewed for this article, there is an enormous gap in nursing science on this topic. With the absence of empirical evidence, the accepted practice of nurse listening is based on assumptions and not the patient's reality. As a nurse executive, empirical data associated with practice to enhance the patient's experience of nurse listening in a hospital setting is paramount to changing performance, while embracing quality and respect. In addition, patient satisfaction is a component of performance and impacts the fiscal wellbeing of the hospital. Through research focused on the hospitalized patient's experience with nurse listening, guidance will be provided to intervene through education from the lens of the patient's perception of listening, supporting the quality and financial bottom lines.

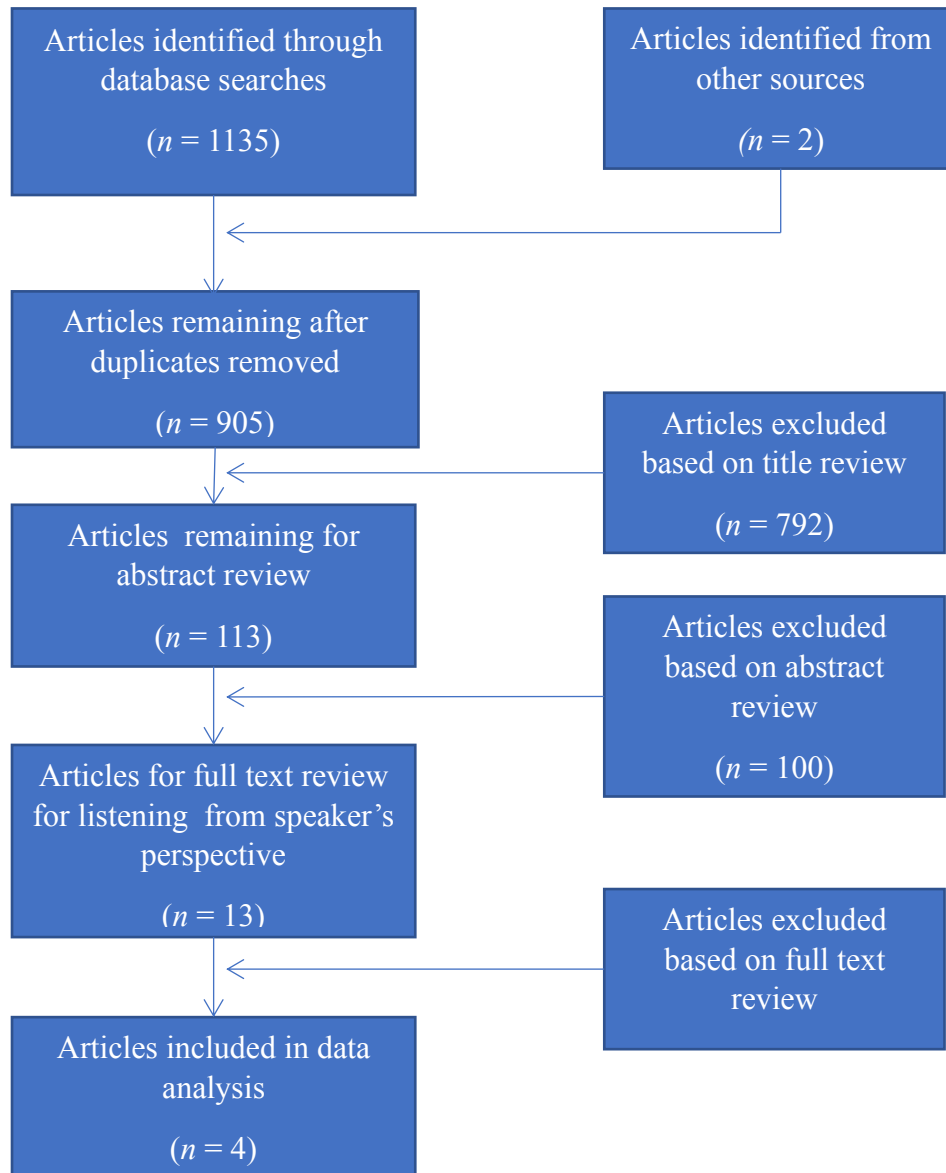
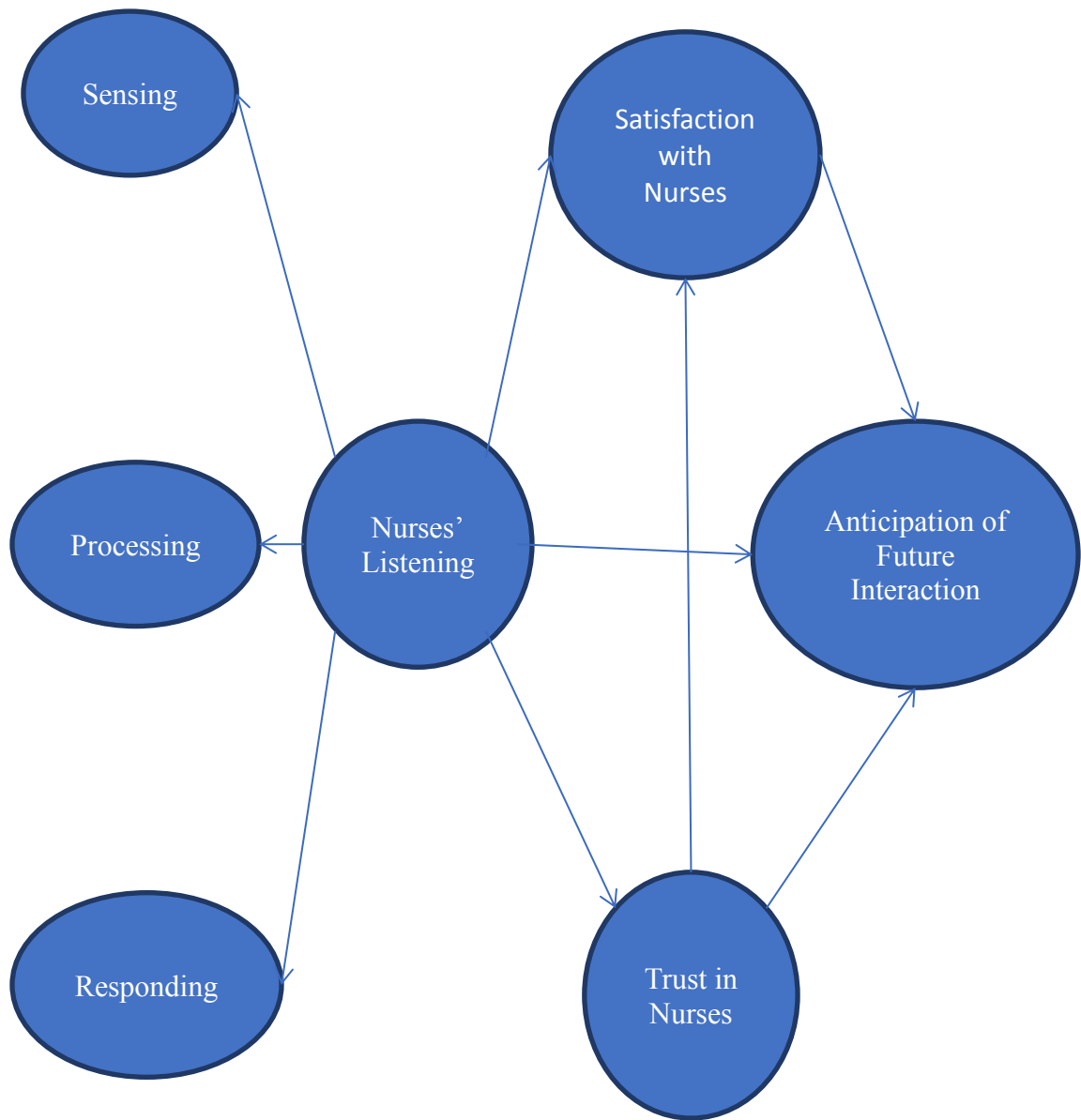


Figure 2.1: Flow diagram for literature search and reduction for analysis.



*Figure 2.2: “Conceptual model for active empathetic listening  
Adapted from Ramsey & Sohi (1997, p. 128).”*

Table 2.1:  
Integrated Literature Review – Being Listened To

Reference	Study Purpose or Research Question(s)	Study Sample	Study Design	Study Analytic Method	Major Study Findings
Bodie et al., 2012	Question: What are the attributes (what listening is) and behaviors (what listeners do) associated with competence in listening especially as they pertain to initial interactions? Studies build on an empirical database of attributes (what competent listening is) and behaviors (what competent listeners do) associated with effective listening during an initial interaction.				
	Study #1: Generate a list of general traits and specific behaviors that participants readily associate with competent communication and ascertain the degree to which any of them are related to impressions of good listening.	352 undergraduate students (209 female) enrolled in Communication Studies courses at Louisiana State University (LSU). Mean age 20.44 years old, primarily Caucasian ( <i>n</i> = 285) and represented 9 majors	Quantitative – Computerized tool participants entered up to 20 characteristics or behaviors, one at a time, they felt contributed to someone in the initial interaction who was “communicatively competent”.  Computer generated list of each response and participant rated on a 6-point scale if definitely a characteristic of <i>listening competence</i> (6) or definitely not (1)	3102 individual responses to open-ended question. Open coding performed, leading to coding scheme with sufficient inter-coder reliability established	Communication skill categorization list (p. 6): Eye contact ( <i>n</i> = 161) Questioning ( <i>n</i> = 59) Responsiveness ( <i>n</i> = 105) Understanding ( <i>n</i> = 173) Listening ( <i>n</i> = 107) Pays attention ( <i>n</i> = 119) Clarity ( <i>n</i> = 64) Conversational flow ( <i>n</i> = 312) Intelligence/competence ( <i>n</i> = 403) Friendly/polite ( <i>n</i> = 243) Confident/extraversion ( <i>n</i> = 209)

Reference	Study Purpose or Research Question(s)	Study Sample	Study Design	Study Analytic Method	Major Study Findings
					<p>Nonverbal/body language (<i>n</i> = 383)</p> <p>Humor (<i>n</i> = 88)</p> <p>Unable to code (<i>n</i> = 676) – didn't appear enough to validate additional category</p> <p>Overall, participants indicated that a nod, show of interest, maintain eye contact, ask questions, demonstrate understanding, do not interrupt, and smile are viewed as competent listeners.</p>
	<p>Study #2: Address limitations of Study #1. First, cross-validate relationship between each category of skill and listening competence with an independent sample of participants. Second, identify specific behaviors</p>	<p>150 undergraduate students (112 female) enrolled in Communication Studies courses at LSU. Mean age 20.29 years old, primarily Caucasian (<i>n</i>=136) and represented 13 majors. No participants had</p>	<p>Quantitative – Participants randomly assigned to one of six conditions and directed to computers to list behaviors that lead them to think someone was understanding, a good listener, responsive, paying attention, enabling conversational flow, or friendly. Computer generated list of each</p>	<p>Descriptive statistics with 95% confidence intervals from Study #1</p> <p>712 open-ended responses across six attributes with 365 retained for coding as specific behaviors as determined by two of the authors.</p>	<p>Validating Study#1 results: The following related to listening competence:</p> <p>Pays attention</p> <p>Responsiveness</p> <p>Eye contact</p> <p>Questioning</p> <p>Understanding</p> <p>Humor – unrelated?</p>

Reference	Study Purpose or Research Question(s)	Study Sample	Study Design	Study Analytic Method	Major Study Findings
	associated with specific listening attributes.	completed Study #1.	response and participant rated on a 6-point scale if definitely a characteristic of <i>listening competence</i> (1) or definitely not (6). Second part of study completed by computer survey where participant completed scale assessing the relationship of categories from Study #1		<p>Clarity – unrelated?</p> <p><u>Specific listening behavior categories:</u></p> <p>Eye contact (listed &gt; 10% of the time)</p> <p>Head nods</p> <p>Asks questions</p> <p>Facial expressions</p> <p>Focused body language/position</p> <p>Hand gestures</p> <p>Smiles/laughs</p> <p>Tells jokes/is witty</p> <p>Verbal and physical composure</p> <p>Paraphrasing</p> <p>Extended responding (listed 9%)</p> <p>Back channel responding</p> <p>Self-disclosure</p> <p>Interrupting/changing subject</p>



Reference	Study Purpose or Research Question(s)	Study Sample	Study Design	Study Analytic Method	Major Study Findings
					<p>Offers advice, opinion, perspectives, and personal experience (listed 25.6% of the time)</p> <p>Subject-appropriate responding (listed 9%)</p> <p>Answers questions</p> <p>Finding common ground</p> <p>Conversation initiation</p> <p>Participants generating <i>behaviors for good listening</i> listed the following making up two-thirds of the behaviors listed:</p> <p>Eye contact</p> <p>Focused body language/position</p> <p>Head nods</p> <p>Extended responding</p> <p>Subject appropriate responding</p>
Clementi, 2006	Purpose: Explore patient's perceptions about feeling listened to	Convenience sample of eighteen male (12) and female	Qualitative Grounded theory with semi-	Content analysis following constant	Attentive through body language (smile, positive facial expressions, engaging in eye contact) and responding based on content and

Reference	Study Purpose or Research Question(s)	Study Sample	Study Design	Study Analytic Method	Major Study Findings
	by nurses, doctors, and healthcare providers.	(6) patients ranging from 52 to 81 years old who attended an appointment at heart failure clinic in large Midwestern Medical Center or in the patient's home	structured oral interviews	comparative methodology	feelings being shared. Made time to listen and took concerns seriously.
Jonas-Simpson et al., 2006	<p>Purpose:</p> <ul style="list-style-type: none"> <li>• Contribute to a knowledge base about the experience of being listened to as described by adults receiving long-term care.</li> <li>• Expand concepts of the human becoming theory.</li> <li>• Specify directions for practice that invite dialogue</li> </ul>	Nineteen English speaking residents (volunteered) between the ages of 70 and 90 years old from two long-term care settings in large urban area of Canada.	Qualitative descriptive	Thematic analysis	<p>Three themes identified: nurturing contentment, vital genuine connections, and deference triumphs mediocrity.</p> <p>Nurturing contentment was about good feelings, satisfaction, gratification and unburdening that comes with being listened to (p. 49).</p> <p>Vital genuine connections were described by participants as relationships with those who listen as being close like friends or family (p. 49).</p>

Reference	Study Purpose or Research Question(s)	Study Sample	Study Design	Study Analytic Method	Major Study Findings
	<p>about being listened to as defined by adults receiving care.</p> <ul style="list-style-type: none"> <li>• Provide ideas for additional research.</li> </ul> <p>Research objectives:</p> <ul style="list-style-type: none"> <li>• Describe the meaning of being listened to.</li> <li>• Describe the patterns of relating, which are connected to being listened to.</li> </ul> <p>Describe what is hoped for with regard to being listened to.</p>				<p><b>Being listened to</b> was described as: they look you in the eye, face shows some emotion (not smiling when you tell the awful story), when somebody drops what they're at and turns to you, expression on their faces not looking someplace else, expression in the eye, movement of the face, face, hand, body language means more than words, the attention that I get from a person</p> <p>Deference triumphs mediocrity is about the reality that respect and the benefits of being listened to more poignant than disregard in institutions where neutrality is expected (p. 50).</p>
Myers, 2000	Explore empathetic listening from the vantage point of	Five female clients $\geq 25$ years old using discriminate	Qualitative – open-ended phenomenological	Excerpts from interviews and narratives analyzed.	All participants identified <b>being listened to</b> as an essential aspect of the therapeutic bond. Participants experienced being heard when

Reference	Study Purpose or Research Question(s)	Study Sample	Study Design	Study Analytic Method	Major Study Findings
	clients engaged in therapeutic relationships.	sampling (selected with voluntary participation) and two therapists at a university counseling center	interview and written narratives		therapists created a safe space for self-exploration, were actively and genuinely engaged in dialogue (paraphrasing, clarifying, questioning, and remembering details), and did not flinch when painful material was brought in the therapeutic process (p.148)

Table 2.2:  
Summary of Listening Behaviors Identified in each Study

Bodie et al., 2012 Study #1	Bodie et al., 2012 Study #2	Clementi, 2006	Jonas-Simpson et al., 2006	Myers, 2000
<ul style="list-style-type: none"> <li>• Nod</li> <li>• Show of interest</li> <li>• Eye contact</li> <li>• Questions asked</li> <li>• Understanding demonstrated</li> <li>• No interrupting</li> <li>• Smiling</li> </ul>	<ul style="list-style-type: none"> <li>• Head nods</li> <li>• Focused body language/ position</li> <li>• Eye contact</li> <li>• Extended responding</li> <li>• Subject-appropriate responding</li> </ul>	<p>Attentive through body language:</p> <ul style="list-style-type: none"> <li>• Positive facial expressions</li> <li>• Engaging in eye contact</li> <li>• Smile and</li> <li>• Responding based on content</li> <li>• Feelings being shared</li> <li>• Made time to listen</li> <li>• Took concerns seriously</li> </ul>	<ul style="list-style-type: none"> <li>• Look you in the eye</li> <li>• Faces show some emotion</li> <li>• Drops what they're at and turns to you</li> <li>• Expressions on their face not looking somewhere else</li> <li>• Expression in the eye</li> <li>• Movement of the face</li> <li>• Face, hand, body language means more than words</li> </ul>	<ul style="list-style-type: none"> <li>• Created a safe space for self-exploration</li> <li>• Actively and genuinely engaged in dialogue (paraphrasing, clarifying, questioning, remembering details)</li> <li>• Did not flinch when painful material was brought in the therapeutic process</li> </ul>

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## CHAPTER III

### PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

#### **Research Design**

To assess patients' perceptions of nurse listening, this study used a non-experimental descriptive design. Consistent with the aim of this study, a two-group comparison design was used to determine if there was a difference between effective and ineffective nurse active empathetic listening behaviors as perceived by patients discharged from an acute care hospital. The two groups representing effective versus ineffective active empathetic listening (AEL) behaviors were determined by an initial filter question.

#### **Setting**

The setting for this study was a large metropolitan hospital in the south-central region of the United States. The inpatient acute care units participating in this study were purposively selected to represent medical and surgical patient populations with sizable patient volumes/discharges. Based on discharge to home data from January – June 2018, six units were identified. Three of the six units represented medical services and the other three represented surgical services. Permission was obtained to conduct the study from the hospital study site. In addition, approval to conduct the study was obtained from each patient care unit included after providing the Clinical Managers, Patient Experience Ambassadors assigned to the units, and Patient Experience Department leadership with an overview of the study.

## Population and Sample

The participants in this study were adults who experienced an inpatient hospitalization on the selected medical and surgical patient care units. The study inclusion criteria were patients who were:

- Adults  $\geq$  18 years of age,
- English speaking, reading, and writing (query at time of admission – “What is your preferred language” with response of English),
- Discharged to home from the hospital from units included in study.

Exclusion criteria included patients who were unable to provide a physical or virtual address that could be used by the researcher to mail or email the AEL scale survey for completion. The limitation of English reading, writing, and speaking as inclusion criteria and the demographic data point was to address any translation or cultural misinterpretation.

To achieve adequate power for an independent sample *t*-test, a *priori* power analysis using G\*Power 3.1.9 was conducted with moderate effect size of 0.5 (d), power of 0.8, and an alpha level of 0.05. It was determined that a sample size of 102 was needed for the independent *t*-test (one tailed) or 128 for a two tailed *t*-test. A reasonably balanced distribution between patients who responded positively versus negatively to the introductory filter question was needed for the two-group comparison. For the purposes of this study, positive response was considered a score of 7 or 8 on the Likert scale and a score of  $\leq$  6 was considered negative based on the scoring methodology used for HCAHPS results. The HCAHPS results are reported as “top box” defined as the most positive response based on

the scale used for the survey question (HCAHPS, April 2018). The composite scores represent the percentage of patient who chose the “most positive” survey response provided for the dimension (U.S. Department of Health and Human Services Center for Medicare and Medicaid, 2017). The “top box” for the HCAHPS composite for “Communication with Nurses” has four choices for patients to rate their experience with the most positive being “always.” The HCAHPS “Overall Hospital Rating” most positive responses or “top box” scores are defined as a 9 or 10 rating (HCAHPS, April 2018). Therefore, the scale used for this study provided eight choices for the patient responses with the most positive being “the most possible” and, similar to HCAHPS a response of 7 or 8, was considered as positive.

### **Protection of Human Subjects**

Approval was obtained from the hospital’s Institutional Review Board (IRB), Institutional Privacy Office, and Texas Woman’s University’s IRB prior to implementation of the study. A daily report of patients meeting the inclusion criteria from the identified patient care units was provided to the Principal Investigator (PI) by the hospital’s Information Systems Department (ISD). The report included the patient’s address provided at the time of hospital registration. If both an electronic address and home mailing address were provided, the PI used the electronic address to distribute the survey via the PsychData web-based encrypted survey software. The electronic survey tool included an informed consent statement prior to accessing the study instruments. If the survey distribution method was a mailing address, the same consent information was provided with the survey tools in paper format for a potential participant to agree or disagree with study participation. The

consent addressed the purpose of the proposed study, eligibility criteria, time commitment, potential risks and benefits, measures to ensure confidentiality, and a statement as to the participant's right to decline participation at any point during the study. Each subject's demographic form and survey was assigned an identification (ID) code number. For those subjects who received a mailed copy of the survey, the ID code was written on the survey tools by the PI prior to mailing. A stamped envelope addressed to the researcher was provided for return of the demographic form and survey. If the survey was sent online, the subject was assigned a unique Respondent ID# to maintain confidentiality. The completed surveys and demographic forms will be maintained in a double locked cabinet in the PI's home and will be destroyed five years following the completion of the study. The electronic online PsychData survey reports and data were downloaded, printed and stored as above and deleted from the encrypted database. Research reports for the dissemination of findings will only include aggregate data.

### **Instrument**

Subjects who volunteered to complete the two study instruments were enrolled in this study. The first was the demographic data collection form (see Appendix A) and the second was the AEL scale survey tool and study questions (see Appendix B). Demographic data collected from all participants included age, ethnicity, gender, hospital length of stay, type of hospitalization (surgical or medical), English as first language, and recent hospital readmission. These variables were selected to determine if the participants were a representative sample of the inpatient medical surgical population being studied. The

aggregate demographic data were used to answer the research question ‘is there a difference in the demographics of patients who perceive nurses employ active empathetic listening behaviors versus those who do not?’

The AEL scale is the instrument that was used to determine patient’s perceptions of nurse listening. Permission to use this tool was obtained from Tanya Drollinger, PhD who developed the tool with Comer and Warrington (2006). Exploratory factor analysis was used to refine the scale from 21 items to 11. The 11-item tool is grouped in the three subscales of listening representing sensing (items 1-4), processing (items 5-7), and responding (items 8-11). Each item is scored using a 7-point Likert scale: score of 1 is defined as *never or almost never true* to score of 7 *always or almost always true* and 4 *occasionally true*. Based on the literature, the AEL scale was used to evaluate listening behaviors of salespersons (Drollinger et al., 2006), supervisors (Fenniman, 2010), and communication students (Bodie, 2011). Bodie’s (2011) studies sought to determine if the AEL scale created in the context of salesperson-client relationships could be adapted to examine other interpersonal relationships. The AEL scale was adapted and pilot tested by the PI for this study for use with nurses.

Reported internal consistency levels range from .74 to .94 for the three subscales (Bodie, 2011; Drollinger et al., 2006; Fenniman, 2010). Construct validity levels have been reported ranging from .81 to .85 (Drollinger et al, 2006). The internal consistency with Cronbach’s alpha at .86 and .94 for the total scale for Bodie’s two studies is consistent with the resulting alpha of .93 for the pilot study conducted by the PI. The subscales for

the studies ranged from .66 - .89 (Bodie, 2011, Drollinger et al., 2006; Fenniman, 2010) and were also consistent with the pilot study results of alpha .84 - .87. The reliability of the AEL instrument applied across salespersons, supervisors, and communication students, further supports Bodie's hypothesis that the tool can be used to study a variety of interpersonal relationships. The levels of internal consistency at the subscale and total scale supports the conceptual model that sensing, processing, and responding work together to produce a higher-order listening construct (Ramsey & Sohi, 1997).

### **Data Collection**

After IRB approvals were obtained, the PI contacted the hospital's ISD for initiation of the daily reports for patients meeting inclusion criteria. The reports were sent to a password protected computer accessible only by the PI.

For this study, the AEL scale and other referenced study questions were administered in a paper or electronic survey format. Within a minimum of 15 days after each subject was discharged from the hospital, the survey tool was mailed or made available electronically. A cover letter/message (see Appendix C and Appendix D) was sent with the survey which invited the patient to participate in the research study and explained that participation was voluntary. This time lag was required to be in compliance with the CAHPS<sup>®</sup> Hospital Survey (HCAHPS) CMS Quality Assurance Guidelines (Center for Medicare and Medicaid Services, 2018) intended to limit survey burden and prevent potential bias to the HACHPS survey results.

Upon receipt of the completed survey all data was loaded onto a database. Individuals who responded to the first question (Did your nurses listen to you throughout your hospitalization?) with a 7 or 8 rating were placed in Group A (patients who perceive nurses exhibit AEL behaviors) and those who responded with a score of 6 or less were placed in Group B (patients who perceive nurses did not exhibit AEL behaviors). A concluding question was added to the end of the survey which asked the patient to identify the one item from the AEL 11-item tool that was most important to them.

### **Pilot Study**

During the fall semester of 2013, a pilot study spanning 7 weeks (October 1 – November 14) was conducted to exercise the feasibility of the research method and AEL survey instrument. Two inpatient acute care units were randomly selected: one representing a medical patient population and one surgical. Surveys were mailed to 129 eligible patients meeting the inclusion criteria who consented to participate, and 50 participants returned the survey, resulting in 46 completed tools, yielding a response rate of 39%. The initial question on the survey was meant to be a filter to separate the subject responses into different groups for comparison. Of the 46 participants, 42 (91.3%) responded *yes* to “Did your nurses consistently listen to you throughout your hospitalization?” and 4 (8.7%) participants responded *no*. Due to the lack of discrimination, data from the pilot study was descriptively analyzed as a single group. The procedure for the pilot study participant recruitment was brief and successfully applied by the Research Assistant throughout the pilot study. The instrument was



straightforward and limited to two pages for ease of timely completion. The survey tool was accurately completed with minimal missed data. The pilot provided results consistent with the literature and conceptual framework.

Changes made to the current study based on the pilot included the modification of the filter question response options on the survey instrument from a yes/no response to a Likert scale of 1 to 8 with 1 representing *not at all* and 8 *the most possible* to better discriminate between the two groups for comparison. An additional change made in the current study was expanding the survey distribution method to include an electronic survey option.

### **Treatment of Data**

Patient identifiers were only used for the distribution of the survey with either electronic or paper format. Completed survey data were identified by a code and were not linked to participants' names or addresses, including IP addresses. Study data were stored in the PsychData encrypted and password protected server. Data from paper surveys were entered into PsychData by the PI and downloaded for analysis. Only de-identified data was downloaded on a password protected computer for analysis. All study data in paper form was maintained in a double locked cabinet in the PI's home office. Five years following study completion, all paper documentation will be shredded, and electronic data will be disposed.

Data were analyzed using the IBM SPSS Statistics version 25 and a significance level of  $p \leq .05$  was set. Descriptive statistics were calculated for all demographic and

outcome variables (means and standard deviations for continuous variables; frequencies and percentages for categorical variables). An independent *t*-test (two-tail) was used to determine if there was a significant difference between the two groups (those who perceive nurses had positive empathetic listening behaviors versus those who do not). To assess if there is a significant difference in the demographic variables of patients in the two groups, cross tabulation using Chi-square test was applied to the categorical data (gender, ethnicity, whether they were a medical or surgical patient, whether English is first language, and if they have had recent hospitalization) and an independent *t*-test (two-tail) was used for the age demographic. The Mann Whitney U test was used to analyze the length of stay in the hospital due to the skewed data distribution. A rank order of response item frequency was calculated to answer the third research question on which of the characteristics of active empathetic listening behaviors are perceived by the patients as most important. In addition, the internal consistency of the AEL scale was evaluated by calculating the Cronbach's alpha for the subscales (assessing, processing, and evaluating) and total score.

## CHAPTER IV

### CHAPTER SUBMITTED FOR PUBLICATION

A Paper Submitted For Publication in

*Nursing Economic\$*

Karen K. Myers

#### **Nurses' Active Empathetic Listening Behaviors from the Voice of the Patient**

##### **Introduction**

Patients spend more time with nurses than any other health care professional. The major conduit of information between the patient and the health care team are nurses; therefore, it is essential for nurses to be good communicators. Listening carefully is at the core of good communication and is a key element of patient safety and experience (Balik & Dopkiss, 2010). A key component of nurse-patient communication is the patient's perception of their experience with the nurse listening to them. Despite the known importance and impact on patient experience, quality outcomes, and reimbursement, there is a gap in research on effective nurse communication from the patient's perspective.

Healthcare's shift from volume to value requires hospitals to focus on performance and quality outcomes, such as patient experience, as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The nursing communication domain within the survey has the greatest impact on the

patient's overall experience score (Studer Group, 2012). The first series of HCAHPS survey questions focuses on "your care from nurses" (AHRQ, 2018, p. 1) and asks about being treated with courtesy and respect, nurse listening, and the nurse's ability to explain things in a way the patient can understand. Patient experience, a key hospital performance metric, is a component of Value Based Purchasing (VBP). For FY17, the VBP program affected 2.0% of the base operating payments in hospitals resulting in \$1.7 billion in Medicare payments being withheld from hospitals with poor performance on the HCAHPS survey (Becker's Hospital Review, 2017). According to research findings by Press Ganey, hospitals focusing on improving the nurse communication metric could potentially influence 15% of their VBP incentive payment (Rodak, 2013).

Press Ganey (2013) conducted a hierarchical variable clustering analysis on all eight HCAHPS dimensions. The variable clustering analysis identifies multiple measures that "hang together" consistently, while the hierarchical analysis identifies the measure that leads the others in the cluster. Five of the eight dimensions consistently clustered with nurse communication, which is also the dominant dimension. On the basis of this analysis, it is probable that the other four dimensions in the cluster (responsiveness of hospital staff, pain management, communication about medication, and overall rating) would experience an improvement in performance if hospitals focused on improving the nurse communication dimension. Identified as the "rising tide" measure, the findings of this study support hospital prioritization of strategies focused on improving nursing communication, with potential positive impacts beyond VBP (Press Ganey, 2013).

Three qualitative studies involving patient/client's viewpoint of being listened to were performed in outpatient settings in Canada (Jonas-Simpson, Mitchell, Fisher, Jones & Linscott, 2006; Myers, 2000) and one in the United States (Clementi, 2006). The consistent finding from these studies was the feeling of being listened to is gratifying. The common listening observed trait was facial expression of the caregiver during caregiver-patient dialogue. Students enrolled in communication studies who participated in a quantitative study (Bodie, St. Cyr, Pence, Rold, and Honeycutt, 2012) identified characteristics/behaviors perceived as demonstrating listening competence. Bodie et al.'s (2012) findings were behaviors such as head nods, focused body language/position, eye contact, extended responding, and subject-appropriate responding indicated competent listeners. The common themes across these four studies can be categorized into verbal and non-verbal responses. The use of questions and subject/content responses were the verbal behaviors. The non-verbal responses included body language described as head nod, body position, eye contact, smiling, and facial expressions/emotions. Limited research has been conducted in nursing science on the topic of listening, with the majority of prior research focused on listening from the nurse's perspective. Research done by Drollinger, Comer and Warrington (2006), incorporates the terminology of AEL as a form of listening in which the active listening process is combined with empathy to attain a higher form of listening. The researchers confirmed that AEL supported salespeople in a deeper understanding of their customers while separating their personal feelings from the messages (Drollinger et al, 2006). The purpose of this study is to

distinguish between effective and ineffective nurse AEL behaviors as perceived by adult inpatients from an acute care hospital.

## **Methods**

A non-experimental quantitative two-group comparison descriptive study was used to assess patients' perceptions on nurse listening. The study sought to explore the following research questions:

1. Do patients admitted to an acute care hospital perceive a difference between nurses who exhibit active empathetic listening behaviors and those who do not?
2. Is there a difference in the demographics of patients who perceive that nurses employ active empathetic listening behaviors versus nurses who do not?
3. Which of the characteristics of active empathetic listening behaviors are perceived by the patients as most important?

The setting for this study was a large metropolitan hospital in the south-central region of the United States. Approval for the study was obtained from the hospital's Institutional Review Board (IRB), Institutional Privacy Office, and the university IRB. The study invitation and survey tools were distributed to qualifying patients to their email or home addresses provided at the time of admission to the hospital. The informed consent was incorporated into the introductory section of the electronic survey or enclosed with the paper copy if sent to a home address.

***Study Participants.*** The participants in this study were adults who experienced an inpatient acute care hospitalization and were discharged from one of the pre-selected

medical and surgical patient care units. Inclusion criteria were patients who were at least 18 years of age, English speaking, reading and writing (query at time of admission – “What is your preferred language” with response of English), and discharged to home from the hospital from the units included in the study. Exclusion criteria included patients who were unable to provide a physical or virtual address that could be used by the researcher to mail or e-mail the study instruments.

***Instruments.*** Two instruments were used in the study: a demographic data form and the AEL scale. The demographic data collected from participants included age, ethnicity, gender, hospital length of stay, type of hospitalization (surgical or medical), whether English is their first language, and any recent hospital readmission(s). These variables were selected to determine if the participants were a representative sample of the inpatient medical surgical population being studied.

The AEL scale is an instrument originally designed to measure active empathetic listening of salespeople (Drollinger, Comer & Warrington, 2006) and permission was obtained to use it in this study. Drollinger et al. (2006) used exploratory factor analysis to refine the scale from 21 items to 11. The 11-item tool is grouped in the three subscales of listening representing sensing (items 1-4), processing (items 5-7), and responding (items 8-11). Each item is scored using a 7-point Likert scale: score of 1 is defined as *never or almost never true* to score of 7 *always or almost always true* and 4 *occasionally true*. The participants scored each of the 11 items individually based on the perception of the nurse’s listening behaviors. *Sensing* is the receipt of both verbal and non-verbal

communication/cues from the speaker (Comer & Drollinger, 1999). The receiver's cognitive processing of the information through understanding, interpreting, evaluation, and remembering is the *processing* phase of listening (Comer & Drollinger, 1999). *Responding* acknowledges information has been received through verbal and non-verbal responses to assure the speaker listening has occurred (Comer & Drollinger, 1999).

Reported internal consistency levels range from .74 to .94 for the 3 subscales (Bodie, 2011; Drollinger et al., 2006; Fenniman, 2010). Construct validity levels have been reported ranging from .81 to .85 (Drollinger et al, 2006). The internal consistency with Cronbach's alpha at .86 and .94 for the total scale for Bodie's two studies is consistent with the resulting alpha of .93 for the pilot study conducted by the PI. The subscales for the studies ranged from .66 - .89 (Bodie, 2011, Drollinger et al., 2006; Fenniman, 2010) and were also consistent with the pilot study results of alpha .84 - .87. The reliability of the AEL instrument applied across salespersons, supervisors, and communication students, further supports Bodie's hypothesis that the tool can be used to study a variety of interpersonal relationships. The levels of internal consistency at the subscale and total scale supports the conceptual model that sensing, processing, and responding work together to produce a higher-order listening construct (Ramsey & Sohi, 1997).

Based on the literature, the AEL scale has been used to evaluate listening behaviors of salespersons (Drollinger et al., 2006), supervisors (Fenniman, 2010), and communication students (Bodie, 2011). The AEL scale was adapted for this study to determine patient's perceptions of nurse listening. Two questions were added for the



purposes of the study. The first question, “Did your nurses listen to you throughout your hospitalization?”, served as a filter to create two groups for comparison. The patient was asked to respond on an 8-point Likert scale with 1 being *Not at All* and 8 being *The Most Possible*. The final question on the survey asked the patient to identify the one item from the AEL 11-item tool that was most important to them.

**Data Collection.** After IRB approvals were obtained, the primary investigator (PI) contacted the hospital’s Health System Information Systems Department for initiation of daily reports for patients meeting inclusion criteria. The reports were sent to a password protected computer accessible only by the PI. The list of patients meeting criteria included the patient’s address provided at the time of hospital registration. If both an email address and home mailing address were provided, the PI used the email address to distribute the survey via the PsychData web-based encrypted survey software. Data were collected in 2019 over an 8-month period. The researcher sent out over 3,000 email surveys and an additional 2,000 were sent via the U.S. postal service. A total of 305 surveys were returned (4.7% electronically and 8.6% via the mail). A cover letter/message was sent with the surveys explaining the purpose of the survey and inviting the patients to participate in the research study, which was voluntary. The participants who provided only a mailing address were also sent a pre-addressed and stamped return envelope addressed to the PI. The study invitation and survey were distributed within a minimum of 15 days after discharge. This time lag was required to be in compliance with the CAHPS® Hospital Survey (HCAHPS) CMS Quality Assurance

Guidelines (Centers for Medicare and Medicaid Services, 2018) intended to limit survey burden and prevent potential bias to the HCAHPS survey results.

Upon receipt of the completed surveys, all data were loaded into a database. Individuals who responded to the first question (Did your nurses listen to you throughout your hospitalization?) with a 7 or 8 rating were placed in Group A (patients who perceive nurses exhibit active empathetic listening behaviors), and those who responded with a score of 6 or less were placed in Group B (patients who perceive nurses did not exhibit active empathetic listening behaviors).

**Data analysis.** Data was analyzed using the IBM SPSS Statistics version 25 and a significance level of  $p < .05$ . Descriptive statistics were calculated for all demographic and outcome variables (means and standard deviations for continuous variables; frequencies and percentages for categorical variables). An independent  $t$ -test (two-tailed) for unequal variances was used for all but two of the AEL scale questions to determine if there was a significant difference between the two groups (those who perceive nurses had positive empathetic listening behaviors versus those who do not). To assess if there was a significant difference in the demographic variables of patients in the two groups, cross tabulation using Chi-square test (Pearson Chi-Square and Cramer's V) was applied to the categorical data (gender, ethnicity, whether they were a medical or surgical patient, whether English is first language, and if they have had any recent hospital readmissions) and an independent  $t$ -test (two-tailed) was used for the age demographic. The Mann-Whitney U test was applied for length of stay in the hospital due to the skewed distribution. A rank order of response item

frequency was calculated to answer the third research question on which of the characteristics of active empathetic listening behaviors were perceived by the patients as most important. In addition, the internal consistency of the AEL scale was evaluated by calculating the Cronbach's alpha for the subscales (assessing, processing, and evaluating) and total score.

## **Results**

*Demographics.* A *priori* power analysis using G\*Power 3.1.9 was conducted using an alpha of .05, effect size of 0.5(d), and power of 0.8 resulting in an estimated sample size of 102 participants for an independent *t*-test (one-tailed) and 128 participants for a two-tailed *t*-test. Some of the 305 surveys returned were not completed, so the final sample consisted of 244 participants. Using the responses to the first question of the survey, were 194 (79.5% of the sample) were placed in Group A (positive perception) and 50 (20.5%) in Group B (negative perception). The average age of the total sample was 59.77 years, with a range of 18 to 95 years old. Males (50.8%) and females (49.2%) were evenly distributed and the majority were white (62%), surgical patients (62.4%), with an average length of stay of 4.77 days (range = 1 to 74). Forty participants (16.7%) had experienced a readmission after the hospitalization in which they met inclusion criteria for the study. There were no statistically significant differences found in the demographic characteristics of the two groups (alpha set at .05; see Table 4.1).

*Survey Results.* The *t*-test (two-tailed) revealed there was a significant difference in the AEL scale total score for Group A ( $M = 6.12$ ,  $SD = .88$ ) and Group B ( $M = 3.89$ ,

$SD = 1.45$ ); ( $t = 10.36, p < .001$ ). Each of the AEL subscales of sensing, processing, and responding also had statistically significant differences between the two groups (Group A's mean scores were 6.01, 5.98, 6.32 respectively and Group B's were 3.94, 3.56, 4.08). The subscale with the highest mean was *responding* (Group A;  $\mu=6.32$ ) and the lowest subscale mean was *processing* (Group B;  $\mu=3.56$ ) (see Table 4.2). In addition, statistically significant differences were found between Group A and B for each of the 11-items comprising the AEL scale (see Table 4.3). Results were confirmed with nonparametric Mann-Whitney U tests because the groups were of unequal size.

The last question on the survey asked participants to identify which characteristic from the 11-item AEL scale was most important to them as a patient. The characteristic that was identified the most (21.6%) was "The nurses understood how I felt," belonging to the sensing subscale. The second, third and fourth highest, made up 41.4% of the total responses and were all characteristics of the responding subscale (see Table 4.4).

The AEL scale overall internal consistency using Cronbach's alpha reliability was 0.965. All the item-item correlations were positive and ranged from 0.564 to 1.000. The Cronbach alpha coefficients for the AEL subscales were 0.915 for sensing, 0.901 for processing, and 0.949 for responding. The subscale item-item correlations were all positive and the reliability for the AEL scale total score and subscales was strong with all Cronbach alpha coefficients exceeding 0.90.

## **Discussion**

With patient experience driving financial, quality, and safety performance, nurses who are at the core of patient interactions need to better understand the impact their communication has on meeting the needs of patients. There were no significant differences in any of the demographics between those participants who perceived their nurses listened to them throughout their hospitalization (score of 7 or 8 on the first survey question) and those who did not (score of 6 or below). This finding suggests that age, gender, ethnicity, surgical or medical, length of hospitalization or readmission do not impact how patients perceive being listened to. This is important given the diversity of our patient population and the fundamental need of being listened to. In a study conducted by The Beryl Institute *Consumer Perspectives on Patient Experience 2018* (Wolf, 2018), 91% of the respondents believed patient experience was either extremely important or very important to them. Being listened to was consistently ranked as the number one factor influencing patient experience across all age groups and internationally (Wolf, 2018).

To establish excellence in the focused area of patient interactions, a foundation of communication skills to meet these needs is essential. Effective listening is the most important part of good communication (Drollinger et al, 2006). The AEL survey instrument captures the main characteristics of listening. This was confirmed by the results of this study. There was a significant difference in the two groups not only in the total AEL score, but for each of the subscales and for each of the individual behaviors.

These results begin to fill the gap on what is important from the patient's perspective in achieving effective communication.

With listening behaviors from the patient's perspective poorly understood, this study is the first to identify effective active empathetic listening behaviors through the lens of the patient. The last question on the survey asked the participants to identify the nurse listening behavior that they perceived as most important. The rank order of importance to the patient may guide the priority of intervention to enhance the perception of being listening to. Prior research studies (Bodie et al, 2012; Clementi, 2006; Jonas-Simpson, et al, 2006; Myers, 2000) identified common verbal and non-verbal characteristics of effective listening. The verbal characteristics of using questions and content appropriate responses may be comparable to the AEL scale items "The nurses asked questions that showed they understood my positions" and "The nurses assured me that they were listening by using verbal acknowledgements." These AEL behaviors ranked second and third as most important to patients. The AEL scale included a similar non-verbal behavior "The nurses showed me they were listening by their body language (e.g. head nods)." In this study, this behavior ranked 4th as most important. These assumed commonalities align earlier findings with this study to further support these as priority behaviors to be addressed in nursing practice.

The AEL scale has been used to evaluate listening behaviors of salespersons, supervisors, and communication students with established reliability. The Cronbach's alphas calculated for the total score as well as each of the subscales exhibited strong

reliability. The reliability of the AEL scale suggests it can be effectively applied across a variety of interpersonal relationships.

The focus on patient experience has gained momentum as a priority in healthcare over the last decade (Wolf, 2018). In a recent survey by the Beryl Institute (Wolf, 2019), patient experience was identified as one of the top three organizational priorities in the next three years. According to a survey conducted by Press Ganey (2018), “Patient experience is five times more likely to influence brand loyalty than other marketing strategies” (p. 1). The cost of poor performance is negatively impacting hospital’s financial bottom lines through pay for performance and consumer loyalty. To address this hospital financial impact, it is imperative to enhance nurse-patient communication and more specifically listening from the patient’s perspective. The growing body of evidence demonstrating the influence nurse communication has on patient experience outcomes further substantiates the need for research such as this study to narrow the gap in nursing science.

*Limitations.* The primary limitation of this study was the use of a convenience sample limiting the generalizability of the findings. Another limitation was the low response rate from both the email and paper surveys. After patients are discharged from a hospital, they can receive multiple surveys from the hospital and other sources, resulting in the potential for survey fatigue. The volume of email communications with the ever-increasing use of electronic methods to communicate could have also resulted in the survey being overlooked. The sample size required for statistical analysis was

achieved only through a commitment to distribute numerous surveys with the response rate so low. Personal contact with the patient prior to discharge from the hospital to inform them of the study and to expect the survey may have resulted in a higher response rate.

The Likert scale used for the response to the filter question “Did your nurses listen to you throughout your hospitalization” ranged from 1 *Not at all* to 8 *The Most Possible* might have been interpreted differently by the participants. With the complex hospital environment where multi-tasking is common, the patient’s observation of busy nurses could have been interpreted as doing “as much as possible” given the circumstances resulting in a more favorable score.

***Implications for practice.*** With the growing evidence of the importance and impact on patient experience focused on nurse-patient interactions, each of the 11 specific listening behaviors included in the AEL scale are behaviors that should be an essential component of nursing education and incorporated into nursing practice. AEL behaviors can be taught and validated in skills labs, simulation, or clinical settings and may favorably influence the patient experience. The rank order of importance to the patient may be a starting point to focus educational resources.

## **Conclusion**

Essential to the establishment of a positive nurse-patient relationship is good nurse communication, including listening skills. With the absence of empirical evidence, the accepted practice of nurse listening is based on assumptions and not the patient’s



reality. The findings from this study begins the journey in addressing the nursing science gap to understand the complex skill of listening from the patient's perspective. This study suggests effective active empathetic nurse listening skills will influence a positive patient experience. Further research needs to be conducted in other hospital settings and locations across the country to fill the gap in knowledge on this critical element of nurse-patient communication impacting quality, safety, and patient experience.

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Table 4.1

*Demographics Characteristic by Group and Overall*

<b>Characteristics</b>	<b>Total** N=244 n(%)</b>	<b>Group A N=194 Positive perception nurse listening n(%)</b>	<b>Group B N=50 Negative perception nurse listening n(%)</b>	<b>p* (two- tailed)</b>	<b>Cramer's V</b>
<b>Gender</b>					
Male	123(50.8)	97(50.3)	26(53.1)	.726	.023
Female	119(49.2)	96(49.7)	23(46.9)		
<b>Ethnicity</b>				.435	.106
White	150(62)	122(62.9)	28(58.3)		
Hispanic	40(16.5)	31(16.0)	9(18.8)		
Black	38(15.7)	28(14.4)	10(20.8)		
Other	14(5.8)	13 (6.7)	1(2.1)		
<b>Surgery</b>				.088	.110
Yes	151(62.4)	125(65.1)	26(52.0)		
No	91(37.6)	67(34.9)	24(48.0)		
<b>English as first language</b>				.302	.066
Yes	225(92.6)	177(91.7)	48(96.0)		
No	18(7.4)	16 (8.3)	2 (4.0)		
<b>Readmission after hospitalization</b>				.379	.057
Yes	40(16.7)	34(17.8)	6(12.5)		
No	199(83.3)	157(82.2)	42(87.5)		
<b>Age <math>\mu</math>(SD)</b>	59.77(16.93)	60.68(17.07)	55.98(15.93)	.091	
<b>Length of stay (days)</b>				.873	
$\mu$ (SD)	4.77(6.28)	4.34(3.95)	6.47(11.42)		

\* $\chi^2$  used for dichotomous and categorical data; *t*-test used for age; Mann-Whitney U test used for LOS due to lack of normal distribution

\*\* not all participants answered every demographic survey item

Table 4.2

*Group Comparison: Subscales and Total Score for AEL scale*

<b>Subscales and Total Tool</b>	<b>Group</b>	<b><i>n</i></b>	<b><i>M</i></b>	<b><i>SD</i></b>	<b><i>t</i>*</b>	<b><i>p</i> (two-tailed)</b>
Sensing	Positive (A)	194	6.0064	1.02298	9.180	<.001
	Negative (B)	50	3.9433	1.50193		
Processing	Positive	193	5.9810	1.17578	10.557	<.001
	Negative	50	3.5633	1.50468		
Responding	Positive	194	6.3174	.85376	9.547	<.001
	Negative	50	4.0783	1.60086		
Total Tool	Positive	194	6.1170	.88223	10.360	<.001
	Negative	50	3.8941	1.44960		

\* Independent *t*-test

Table 4.3

*Group Comparison: Perceived Difference Between Nurses Who Exhibit AEL Behaviors and Those Who Do Not*

Characteristic/Behavior	Listening Perception	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i> *	<i>p</i> (two-tailed)
Sensitive to what I was not saying	Positive	190	6.06	1.24	8.405	<.001
	Negative	48	3.71	1.83		
Aware of what I implied but did not say	Positive	190	5.66	1.49	7.254	<.001
	Negative	45	3.56	1.80		
Understood how I felt	Positive	190	6.31	.93	8.417	<.001
	Negative	48	4.27	1.61		
Listened for more than spoken words	Positive	192	6.05	1.15	9.203	<.001
	Negative	47	3.91	1.49		
Assured me they would remember what I said	Positive	191	5.86	1.53	8.699	<.001
	Negative	50	3.68	1.73		
Summarized points of agreement and disagreement when appropriate	Positive	188	5.99	1.40	10.231	<.001
	Negative	47	3.62	1.51		
Kept track of points I made	Positive	190	6.08	1.14	10.922	<.001
	Negative	47	3.40	1.58		
Assured me they were listening by verbal acknowledgements	Positive	194	6.43	.89	10.255	<.001
	Negative	49	3.98	1.61		
Assured me they were receptive to my ideas	Positive	188	6.16	1.06	7.934	<.001
	Negative	49	3.92	1.90		
Asked questions that showed they understood my positions	Positive	192	6.34	.95	9.181	<.001
	Negative	48	3.98	1.72		
Showed me they were listening with their body language (e.g. head nods)	Positive	192	6.31	.98	7.429	<.001
	Negative	50	4.30	1.84		

\* Independent *t*-test



Table 4.4

*AEL Scale Behavior Most Important to Patients*

<b>Characteristic: The nurses...</b>	<b>Freq.</b>	<b>Valid %</b>	<b>Subscale</b>
...understood how I felt	45	21.6	Sensing
...asked questions that showed they understood my positions	39	18.8	Responding
...assured me that they were listening by using verbal acknowledgements	27	13.0	Responding
...showed me they were listening by their body language (e.g. head nods)	20	9.6	Responding
...were sensitive to what I was not saying	19	9.1	Sensing
...listened for more than just my spoken words	15	7.2	Sensing
...kept track of points I made	11	5.3	Processing
...assured me that they would remember what I said	10	4.8	Processing
...summarized points of agreement and disagreement when appropriate	10	4.8	Processing
...were aware of what I implied but did not say	6	2.9	Sensing
...assured me that they were receptive to my ideas	6	2.9	Responding

Note: AEL Scale adapted from Drollinger et al (2006)

## CHAPTER V

### SUMMARY OF STUDY

With growing evidence of the critical role nurse communication plays in a positive patient experience, the behaviors associated with good communication, more specifically listening, need to be understood. Nurse communication is a key driver in quality, safety, and patient experience; therefore, impacting the bottom lines of hospital performance and reimbursement with pay for performance. The literature reviewed for this study revealed a large gap in nursing science related to effective nurse listening behaviors from the patient's perspective. The dearth of nursing science focused on nurse listening behaviors, pivotal to nurse-patient interactions and experience, was the driver of this study. This descriptive study sought to identify effective nurse active empathetic behaviors from the adult inpatients' perspective.

#### **Summary**

The purpose of this nonexperimental two-group comparison descriptive study was to distinguish between effective and ineffective nurse active empathetic listening behaviors as perceived by adult inpatients from an acute care hospital. The research questions addressed the following:

1. Do patients admitted to an acute care hospital perceive a difference between nurses who exhibit active empathetic listening behaviors and those who do not?

2. Is there a difference in the demographics of patients who perceive that nurses employ active empathetic listening behaviors versus those nurses who do not?
3. Which of the characteristics of active empathetic listening behaviors are perceived by the patients as most important?

This chapter provides a summary of the study conclusions, implications for practice, and recommendations for further research.

The convenience sample of 244 adult patients discharged home from a medical or surgical unit completed the demographic tool and AEL scale tool measuring their perceived experience with nurse listening in an acute care hospital setting. The tools were distributed to qualifying participants either to their email address or home address provided at the time of admission to the hospital. Based on the Likert rating scale (1 *Not at all* – 8 *The Most Possible*) for the filter question, 'Did your nurses listen to you throughout your hospitalization,' two groups were formed for comparison. The participants responding with 7 or 8 were placed in Group A while a response of  $\leq 6$  made up Group B. A disproportionate number of participants were in Group A (194), those who perceived their listening experience was positive. An independent *t*-test (two-tailed), set at alpha of .05, was conducted and confirmed with nonparametric Mann-Whitney U tests (due to unequal group size), which showed a significant difference between the groups ( $p < .001$ ). Each AEL subscale (sensing, process, and responding) and AEL scale item were analyzed with statistically significant differences found between Group A and Group B (Research Question 1).

Descriptive statistics were used for all demographic variables with significant differences between the two groups analyzed using cross tabulation chi-square test for categorical data (gender, ethnicity, whether they were a medical or surgical patient, if English was their first language, and if they had any recent hospital readmissions). An independent *t*-test (two-tailed) was used for age and Mann-Whitney U applied for length of stay due to skewed distribution. No statistically significant differences were found in demographic characteristics between Group A and Group B (Research Question 2).

The responses to the final survey question “Which of the above (11 items in AEL scale) was most important to you as a patient?” were analyzed using a rank order of response item frequency. The highest ranked item was from the sensing subscale with the three that followed in the ranking frequency representing items from the responding subscale (Research Question 3).

The overall internal consistency using Cronbach’s alpha reliability for the AEL scale was 0.965. All the item-item correlations were positive for the total score and subscales. The reliability for the AEL total score and subscales was strong with Cronbach alpha coefficients exceeding 0.90.

### **Discussion of Findings**

The conceptual model used for salesperson listening (Ramsey & Sohi, 1997) was adapted for this study to focus on nurse listening. The framework incorporates three dimensions of listening depicted as sensing, interpreting (processing), and responding. Ramsey and Sohi’s model (1997) depicts the influence customer perception of

salesperson listening has on trust, satisfaction, and anticipation of future interactions. Comer and Drollinger (1999) introduced active empathetic listening through expanding on Ramsey and Sohi's three listening dimensions and delineating effective listening attributes. Comer and Drollinger (1999) define *empathy* as "the ability to discern another person's thoughts and feelings with some degree of accuracy and involves listening on an intuitive as well as a literal level" (p. 15). Further research (Drollinger et al, 2006), culminated in the development of the AEL scale used as the instrument for this study to differentiate effective and ineffective listeners from the customer's perspective.

In alignment with the conceptual model, this study found all 11 AEL behaviors contributed to a positive patient experience. This is supported by The Beryl Institute's study (Wolf, 2018) that identified listening as the most important influence on patient experience as well as an earlier study by Press Ganey (2013) that found that nurse communication within HCAHPS was the dominant dimension and influenced four other dimensions including overall rating. A follow-up study by Press Ganey in 2018 revealed patient experience has a fivefold impact on brand loyalty over other marketing strategies. Hospitals are faced with patient experience and customer loyalty issues that can impact financial performance. The need to understand listening is fundamental to improving the patient experience. The nurse's AEL behaviors found to be significant in this study are a starting place to improve nurse listening behaviors.

The Beryl Institute (Wolf, 2018) reported being listened to was the most important influencer on patient experience from the consumer's perspective across all age

groups and internationally. Results from this study corroborate that finding. The total sample was comprised of 244 participants. There were no significant differences found in any of the demographic variables between the two groups.

The final question of the survey provided insight into which of the 11 AEL behaviors was most important to the individual patient. Prior research studies conducted in other settings identified some common non-verbal and verbal cues characteristic of effective listening (Bodie et al, 2012; Clementi, 2006; Jonas-Simpson et al, 2006; Myers, 2000). The non-verbal behaviors described by these researchers were similar to the AEL item 'The nurses showed me they were listening by their body language (e.g. head nods).' This behavior ranked 4th in this study. Two behaviors which ranked as second and third as most important to the patient in this study, 'The nurses asked questions that showed they understood my positions' and 'The nurses assured me that they were listening by using verbal acknowledgements,' were comparable with use of content appropriate acknowledgements and questions (verbal cues) identified in the literature. The behavior that participants from this study ranked as the most important to them was 'The nurses understood how I felt.' This behavior is similar to the participants in Myers' study (2000) who associated being heard as being empathetically understood. Myers (2000) described this experience of the therapists listening to the participants resulted in a feeling of being understood by the therapist.

The AEL scale had demonstrated reliability in the evaluation of listening behaviors of salespersons, supervisors and communication students. The Cronbach's

alphas for the AEL total score and subscales calculated in this study were strong and the tool distinguished between effective and ineffective nurse listening behaviors. The findings from this study suggest the AEL scale is a reliable tool that can be applied across multiple disciplines and interpersonal relationships and was consistent with Bodie's (2011) validation of the AEL scale for use outside of sales.

The Beryl Institute (Wolf, 2019) has identified patient experience as one of the top three priorities for healthcare organizations over the next three years. The negative impact poor performance has on quality, safety, and satisfaction have pay for performance financial implications for hospitals. It is imperative to enhance nurse-patient communication and more specifically listening from the voice of the patient to address these key performance metrics and, in turn, the overall patient experience.

### **Conclusions and Implications**

Quality, safety, and patient experience are priorities in healthcare. With growing evidence of the interdependence of these areas of focus, the drivers of patient experience from the voice of the patient needs to be better understood. This study is the first to identify effective nurse active empathetic listening behaviors through the eyes and ears of the patient. Conclusions from this study include:

1. The AEL scale is a valid and reliable tool for assessing nurse's active empathetic listening behaviors.
2. There is a significant difference in AEL behaviors perceived by patients within this sample.

3. Demographics were not a determinant of the listening experience as no significant difference was found for any of the biographical characteristics.
4. The highest rank order of AEL characteristics most important to this sample was “The nurses understood how I felt.”

There were several limitations of this study that might have affected the internal validity of this study and therefore limiting generalizability: the use of a convenience sample and the low response rate to both methods (paper and email) of survey distribution. The use of the Likert scale ranging from 1 *Not at all* to 8 *The Most Possible* for the initial filter question may have been understood differently by the participants. In the complex busy hospital environment, the word ‘possible’ may have been interpreted as, ‘what could be expected given the circumstances,’ leading to a more positive rating.

Based on the findings of this study, there are potential implications for nursing practice:

1. Incorporate each of the AEL behaviors into nursing education focused on nurse-patient communication
2. Utilize skills labs, simulation or the clinical setting to reinforce and validate AEL behaviors
3. Incorporate AEL behaviors into recruitment and interviewing nurses to evaluate their communication and listening skills



### **Recommendations for Further Study**

Based on the findings from this study, there are a number of recommendations for further research:

1. Replicate study in different hospital settings and geographic regions.
2. Conduct qualitative studies to better understand the behaviors associated with the highest ranking AEL characteristic.
3. Explore targeted strategies to improve nurse listening behaviors.

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APPENDIX A

Demographic Data Collection Form

## Demographic Data

Code Number: \_\_\_\_\_

Please select the most appropriate answer to the following questions:

**Birth Year:** \_ \_ \_ \_

**Gender:** \_\_\_\_\_ Male      \_\_\_\_\_ Female      \_\_\_\_\_ Transgender      \_\_\_\_\_ Other  
\_\_\_\_\_ Prefer not to say

**Ethnicity:** \_\_\_\_\_ White      \_\_\_\_\_ Black      \_\_\_\_\_ Hispanic      \_\_\_\_\_ Asian  
\_\_\_\_\_ American Indian      \_\_\_\_\_ Pacific Islander      \_\_\_\_\_ Other

**Did you have surgery during this hospital stay?** \_\_\_\_\_ Yes      \_\_\_\_\_ No

**How long did you stay at the hospital?** \_\_\_\_\_ Days

**Is English your first language?** \_\_\_\_\_ Yes      \_\_\_\_\_ No

**Have you been readmitted to a hospital since your hospitalization a few weeks ago?**

\_\_\_\_\_ Yes      \_\_\_\_\_ No

## APPENDIX B

### Active Empathetic Listening Survey Tool and Study Questions

## Active Empathetic Listening Survey Tool

Code Number: \_\_\_\_\_

**A. Did your nurses listen to you throughout your hospitalization?** On a scale of 1 to 8 with 8 meaning “the most possible” and 1 meaning “not at all”, please rate your experience:

1            2            3            4            5            6            7            8

Not at all

The Most Possible

**B. Based on your experience, please respond to the items below using the scale provided:**

	Never or Almost Never True	Usually Not True	Sometimes But Infrequently True	Occasionally True	Often True	Usually True	Always or Almost Always True
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1. The nurses were sensitive to what I was not saying.							
2. The nurses were aware of what I implied but did not say.							
3. The nurses understood how I felt.							
4. The nurses listened for more than just my spoken words.							
5. The nurses assured me that they would remember what I said.							
6. The nurses summarized points of agreement and disagreement when appropriate.							
7. The nurses kept track of points I made.							
8. The nurses assured me that they were listening by using verbal acknowledgements.							
9. The nurses assured me that they were receptive to my ideas.							
10. The nurses asked questions that showed they understood my positions.							
11. The nurses showed me they were listening by their language (e.g. head nods)							

**C. Which one of the above characteristics was most important to you as a patient? Number: \_\_\_\_**

## APPENDIX C

### Invitation to Participate in Study (Paper survey)

**[Invitation to Participate in Study on University Letterhead (Paper Survey)]**

Date

Dear Patient,

My name is Karen Myers and I am a registered nurse. I am a student at Texas Woman's University pursuing my doctoral (PhD) degree. I am conducting a research study to learn more about communication between nurses and patients.

The purpose is to identify listening behaviors of nurses.

You are invited to participate in my research study "Beyond Hearing: Nurses' Active Empathetic Listening Behaviors from the Voice of the Patient". I am conducting this study to learn what needs to happen when patients and nurses talk to each other so that a patient will feel like the nurse has listened to what they are saying.

This study is open to patients who have received care by a nurse in the hospital setting. I am inviting you to participate in this research study because you have been a patient who has experienced care by a nurse in the hospital setting.

Your participation will involve completion of the enclosed the survey. Please review the informed consent and if you agree to participate, your time commitment to complete the survey will be less than 10 minutes. Your total commitment for this study will be about 10 minutes.

Participation in this study is voluntary. Your participation will be kept confidential and your name will not be shared. Your survey has been assigned a code number for confidentiality.

Responses to the survey may be used to teach nurses how to become better listeners when talking with their patients. The overall information gathered may be shared in presentations or journal articles to provide guidance to nurses on how patients would prefer to be listened to.

The first page of the survey is demographic data. On the second page, please respond to the initial question "Did your nurses consistently listen to you throughout your

hospitalization?” using the scale provided. Please respond to the following 11-items using the scale of 1 through 7 displayed at the top of the tool to indicate how frequently you perceive the statements to be true based on your experience with the nurses’ communication. The last question will ask what item was most important to you as a patient. Please return your completed survey in the enclosed self-addressed envelope.

You may also be selected to receive the Memorial Hermann Health System standard patient experience survey. This survey is not part of this research study. Please complete the hospital survey as requested to provide feedback on your experience as a patient.

Thank you in advance for your consideration to participate in this study. Through research such as this, we will be able to continue to enhance patient experience with nurse communication when they are hospitalized.

Sincerely,

Karen Myers, MSN, RN, NEA-BC  
PhD in nursing student  
Texas Woman’s University



## APPENDIX D

### Invitation to Participate in Study (Electronic survey)

### **Invitation to Participate in Study (Electronic survey)**

Dear Patient,

My name is Karen Myers and I am a registered nurse. I am a student at Texas Woman's University pursuing my doctoral (PhD) degree. I am conducting a research study to learn more about communication between nurses and patients.

The purpose is to identify listening behaviors of nurses.

You are invited to participate in my research study "Beyond Hearing: Nurses' Active Empathetic Listening Behaviors from the Voice of the Patient". I am conducting this study to learn what needs to happen when patients and nurses talk to each other so that a patient will feel like the nurse has listened to what they are saying.

This study is open to patients who have received care by a nurse in the hospital setting. I am inviting you to participate in this research study because you have been a patient who has experienced care by a nurse in the hospital setting.

Your participation will involve clicking on the link below and completing a survey. It will take you less than 10 minutes. Your total commitment for this study will be about 10 minutes.

Participation in this study is voluntary. Your participation will be kept confidential and your name will not be shared.

Responses to the survey may be used to teach nurses how to become better listeners when talking with their patients. The overall information gathered may be shared in presentations or journal articles to provide guidance to nurses on how patients would prefer to be listened to.

Thank you in advance for your consideration to participate in this study. Through research such as this, we aim to continue to enhance patient experience with nurse communication when they are hospitalized.

To participate, please click on this link or copy the link into the address bar of browser:

<https://www.psychdata.com/s.asp?SID=183205>

Sincerely,

Karen Myers, MSN, RN, NEA-BC  
PhD in nursing student  
Texas Woman's University