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## Implementing Second Person Reporting in Nurse Practitioner Curricula: A Practical Approach to Person-Centered Care

Collette Tattman-Melo  
*University of Massachusetts Amherst*

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**Implementing Second Person Reporting in Nurse Practitioner Curricula: A Practical Approach  
to Person-Centered Care**

Collette R. Tattman-Melo

College of Nursing, University of Massachusetts, Amherst

DNP Project Chair: Dr Terrie Black

Mentor: Dr Anne Bruce

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## Abstract

*Background:* Nurse handover report inclusive of patient participation has been shown to promote a patient-centered approach to care resulting in increased satisfaction, safety and efficacy. However, a review of the literature suggests the pedagogy of handover report is mainly provided within the “hidden curriculum” of practice, rather than within formal nursing programs. As a result, what constitutes person-centeredness in a handover report is subject to individual interpretation and therefore, practiced inconsistently. *Purpose:* The project goal was for nurse practitioner students to connect theories of person-centered care (PCC) with practice, specifically by using a tripartite, second-person report (SPR) style. *Methods:* Students were provided instruction on the theory and practice of SPR, then asked to use this method of reporting during one semester of clinical practice. Participant surveys were conducted pre-and post-intervention, along with an end-term self-reflection regarding one’s ability to provide PCC. *Results:* Post-intervention quantitative analysis showed a decrease in listening and communication of treatments to the patient, regardless of report method used, while all other measures of person-centered ability improved from pre to post-intervention. This suggests that experience equates to proficiency, which negatively impact’s one’s ability to provide person-centered care. Qualitative reflections demonstrated overall support for SPR as a means to improve person-centeredness. However, time, due to SPR being perceived as less succinct, was a barrier. Participants felt SPR instruction and practice within an undergraduate program would improve student’s ability to perform SPR succinctly as an NP. *Conclusion:* SPR shows promise as a report style that translates theory into the practice of PCC. Formal curriculum, mentorship and practice opportunities may prove to provide a strong foundation for use. More evaluation is required to measure the barriers, benefits and best practice environment for this report style. *Keywords:* SPR, Handover report, students, person-centered, pedagogy, health care

## **Implementing Second Person Reporting in Nurse Practitioner Curricula: A Practical Approach to Person-Centered Care**

### **Introduction**

In recent years, support for person-centered care (PCC) has been in the forefront of organizational practice mandates at all levels, ranging from the World Health Organization ([WHO],2015), to local health authorities, to individuals within organizations (British Columbia Ministry of Health, 2015). However, little attention has been given to the process of person-centeredness within healthcare curriculum (O'Donnell et al., 2017). The addition of formalized curricula, using a model that promotes a practical approach to PCC, can fulfill both small and large-scale government and organizational goals of providing PCC, while increasing student understanding of the theory and practice of this domain.

### **Theoretical and Practice Background**

The WHO identifies education and training as key elements in the process of healthcare reform toward PCC. "Improving the curriculum, new teaching methods and innovative models for both pre-service and in-service training are needed to translate these new competencies into practice" (WHO, 2015, p. 33). Nurse practitioners (NPs), known for their holistic care provision (Kinchen, 2015), are best utilized at the forefront of this reform, thus necessitating PCC education and training within NP programs.

According to the results of a systematic review and concept analysis by Scholl et al., (2014), there are 15 interrelated dimensions of patient-centeredness, thus leading to broad conceptual definitions of PCC. Consequently, the practice of PCC is heterogeneous, and reliant on the interpretations of those who practice it; this is the "hidden curriculum" from which students learn.

In primary care, as NP students demonstrate competence in their clinical history-taking, assessment, and clinical decision-making, preceptors often remove themselves from the clinic room while these activities take place (Ten Cate et al., 2015). The point where the student disengages from the student-patient interaction and seeks out preceptor guidance is when student-preceptor reporting occurs. At this time, details regarding the patient's condition are communicated, and decisions are made based upon these details.

Traditionally, patient to preceptor report is conducted away from the vicinity of the patient. Students relay patient information to their preceptor and the diagnosis and plan for management is confirmed. Students re-enter the patient room, either with or without the preceptor present, and convey the diagnosis and plan to the patient. Some may suggest that this process is person-centered, as the management plan is specific to the unique, biopsychosocial needs of the patient (Scholl et al., 2014). Others may argue that PCC must actively involve patients by engaging them in the conversation (Chaboyer et. al., 2016). The latter is supported here.

The Agency for Healthcare Research and Quality (AHRQ n.d., para 3), refers to PCC as care that is "relationship-based... and *actively supports* patients in learning to manage and *organize their own care* at the level the patient chooses. Recognizing that patients and families are *core members of the care team*, medical home practices ensure that they are *fully informed partners* in establishing care plans" (emphasis added). Conducting report away from the patient promotes paternalistic care, as care is not shared *with* the patient, it is offered *to* the patient. To fully embrace the concepts of PCC, student-preceptor report must actively involve the patient. Students best learn how to do this from evidence-based curriculum that offers a structured practice model, rather than from the varied approach offered by preceptors (Kelly, 2009).

### **Problem Statement**

Within nurse practitioner curriculum, there is a lack of education regarding person-centered reporting methods that occur between student and preceptor. This results in inconsistent, repetitive reporting within clinical practice and increased errors and omissions, thereby reducing patient and student/preceptor provider satisfaction. Providing NP students with formal curriculum on PCC, which includes teaching a specific practical application of patient-centered reporting, addresses this problem.

### **Organizational “Gap” Analysis of Project Site**

A website review of the three university NP programs within British Columbia, Canada revealed no mention of formal instruction around the theory and practice of person-centered care (University of British Columbia, n.d; University of Northern British Columbia, 2020; University of Victoria, 2020).

A specific Canadian university was chosen as the project site for two main reasons. First, as faculty within the chosen university, the DNP student was well-positioned to implement and evaluate a project that focused on the pedagogy and practice of PCC within NP curricula. The DNP student had first-hand knowledge of previous term instruction, and existing curriculum, on the topic associated with the project. Faculty are required to evaluate student’s learning. Thus, existing qualitative student writing assignments were built upon for the purpose of the project and were accessible to the DNP student.

Second, there were no barriers to curriculum development. Faculty within the university’s School of Nursing (SON) are granted *academic freedom* in teaching. In this instance, academic freedom is defined as developing course materials and assessment tasks that promote instructor autonomy and choice, particularly around teaching in areas of interest and specialisms (Karpan, 2018). Within the university NP program, course goals are developed by



the NP Committee in consultation with the Master of Nursing (MN) Curriculum Committee, with final approval from the Graduate Education Committee. Blueprints outline goals, suggested teaching strategies and resources for each course, and are collectively developed to ensure core content is addressed, curriculum is coherent, and repetition is minimized.

The project fit within all the program course blueprints, particularly in regard, but not limited to (Bertoni, 2018):

- Working in and sustaining partnerships and encouraging participation
- Understanding how individual patient factors affect treatment decisions
- Holistic integration of psychosocial, emotional, ethnic, cultural, spiritual and ethical dimensions of health and illness into all client/family encounters
- Examining theories of advanced practice nursing
- Integrating knowledge into discussions and practice with particular attention to providing competent and compassionate care for patients/families within the context of their lives

Introducing a method of PCC reporting within a university program allows for many students to practice this model of reporting in a variety of locations and receive formal instruction in an otherwise hidden curriculum of practice.

### **Review of the Literature**

A comprehensive search for literature regarding person-centered reporting pedagogy and clinical application was conducted. The intent was to understand the benefits and barriers to practicing PCC, as well as to examine report styles.

A database search of Summons 2.0, inclusive of Cumulative Index to Nursing and Allied Health Literature (CINAHL), Education Resource Information Center (ERIC), and PubMed, which incorporates search terms into Medical Subject Headings (MeSH), as well as a search of the

Medline database, was performed. The following search terms were used for both databases: *handover or hand off, nursing student OR medical student and patient-centered.*

Inclusion criteria consisted of full-text, English language journals within medical and nursing professions. The search timeline was limited to the past 10 years (after 2009), relative to the general date of inception of patient-centered concepts (Athanasakis, 2013; Bressan et al., 2019). Articles less than five years were given preference, to utilize current information relevant to today's practices and environment.

Inclusion criteria within the database checklist was originally the medical profession, due to the desire to focus on specific reporting methods of student primary care providers with similar roles; namely physicians, nurse practitioners and physician assistants. There were no results specific to primary care, and limited results specific to medicine (n=53). Therefore, nursing was included in the search criteria, which automatically included hospital environments.

Exclusion criteria were all publications outside of journals, which excludes commentaries and editorials. Within the results, excluded were specialties or practices with patients experiencing diminished capacity to communicate or participate in the report process, as well as telephone, written, or electronic reporting processes.

Medline produced 29 results and Summon 2.0 produced 94 results; 33 were potentially relevant. Using the title, abstract and search terms selection approach, 24 of the 33 articles were eliminated, resulting in 10 meeting inclusion criteria; five qualitative studies, one quantitative, four literature reviews which included one meta-synthesis. For a summary table which includes strength of evidence, see Appendix A.

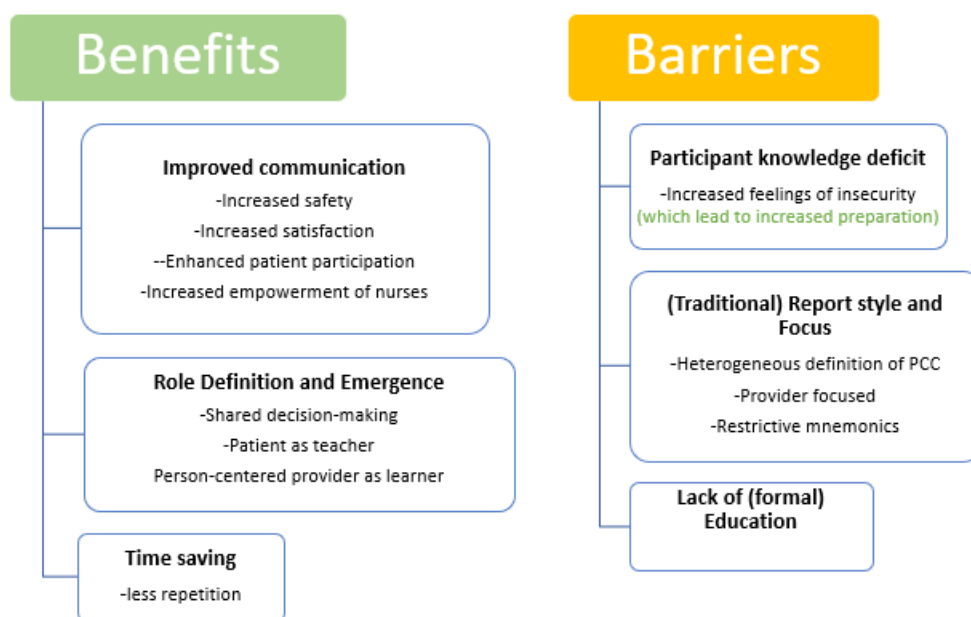
### **Synthesis of the Evidence**

While the majority of the articles referred to in-hospital bedside reporting (Athanasakis, 2013; Bressan et al., 2019; Fealy et al., 2018; Gregory et al., 2014; Kullberg et al, 2018;

Sarvestani et al., 2015; Wray et al., 2016), inferences were made that the effects of person-centered reporting in hospital are the same for primary care reporting. This review of the literature showed a global consistency of positive outcomes regarding increased safety and improved communication when utilizing a patient-centered approach to reporting. Moving beyond these two main consistencies, six themes and multiple sub-themes were found within the analysis of what became the overarching examination of benefits and barriers to implementing person-centered reporting. Figure 1 depicts these themes, followed by a further discussion.

**Figure 1.**

*Benefits and Barriers to Person-Centered Reporting*



**Benefits. Improved Communication Outcomes.** As mentioned, all the articles within this review discussed the benefits of improved safety and increased satisfaction related to improved communication. These two concepts are intertwined, as miscommunication and ambiguity can lead to errors (Bressan et al., 2019). Beyond these two benefits, the exchange of

information using a person-centered approach promotes equality through the use of horizontal communication; further inviting patient participation (Kullberg et al, 2018), a reduction of repetition and redundancy of subjective information (Wray et al., 2016), empowerment of nurses (Gregory et al., 2014) and inspiring confidence in both the patient and provider (Gordon et al., 2018).

Bressan et al. (2019) also found in their meta-synthesis of the literature, that patients developed deeper relationships with those who performed person-centered reporting. Nurses began to “see the person behind the patient emerge” (Kullberg et al., 2018, p. 48), separate from their illness (Oswald et al., 2014). By including the patient in the conversation, the content of the report changes from a solely biomedical focus to include a more holistic focus (i.e., psychosocial) (see, e.g., Athanasakis, 2013; Kullberg et al; Sarvestani et al., 2015). Patients also began to see the nurse beyond the tasks and gained a wider perspective of their scope and competencies (Bressan, et al. 2019). All these benefits are indicative of increased staff and patient satisfaction.

***Role Definition and Emergence.*** Patient-centered reporting allows for the sharing of ideas and responsibilities between patient, families and provider (Sarvestani et al., 2015). Within this process, the patient becomes the teacher, as the expert of their own condition, supporting the student in their learning. Patients discuss and assume some, or all, of the decision-making. Thus, patients define their role in the relationship, moving away from the prescriptive approach to treatment and planning (Sarvestani et al.). Accordingly, the provider’s role becomes one of shared decision-maker, learner, and person-centered provider (Hauer et al., 2010).

***Time.*** Eight of the 10 articles discuss time as being either a benefit or barrier to patient-centered communication (Athanasakis, 2013; Bressan et al., 2019; Fealy et al., 2018; Gordon et

al., 2018; Gregory et al., 2014; Hauer et al., 2010; Kullberg et al., 2018; Sarvestani et al., 2015). In seven articles, a lack of time was stated to be of *initial* concern when implementing person-centered reporting (Athanasakis, 2013; Fealy et al., 2018; Gordon et al., 2018; Gregory et al., 2014; Hauer et al., 2010; Kullberg et al., 2018; Sarvestani et al., 2015). However, only two of seven journals found patient-centered reporting to take longer than other methods of reporting (Fealy et al., 2018; Gordon et al., 2018). In fact, one study found that report time was decreased by one half (Athanasakis, 2013).

**Barriers. *Participant Knowledge Deficit.*** According to Gregory et al. (2014), effective implementation of patient-centered reporting is often overshadowed by one prevailing factor: self-perceived knowledge deficit of both the reporting process and content, leading to insecurity. This insecurity can lead to the avoidance of implementing person-centered report, for fear of being challenged on the information publicly (Bressan et al., 2019; Kullberg et al., 2018). However, these same insecurities lead to the reporters devoting more time to being prepared, which then lead to increased competence and self-assuredness (Kullberg et al.).

Patients have also described feelings of inadequacy in relation to understanding their condition and the medical terminology used during report, impacting their desire to participate in the handover (Bressan et al., 2019; Gregory, et al., 2014; Oswald et al., 2014). Inviting patients to actively participate in the report, and using lay terms, helps to reduce anxieties (Bressan et al., Sarvestani, et al., 2015).

***Report Style and Focus.*** There is a correlation between the lack of consensus on the definition or concept of patient-centeredness, the focus of the report and method of implementation (Kullberg et al., 2018), as discussed herein.

**Variable interpretation of patient centeredness.** In Wray et al. (2016), physicians within the study indicated that patient-centeredness involves discussing information that is

specific to the patient's condition, rather than focusing on including the patient in the conversation; a third person report style is most common. In the literature, when discussing bedside handover report, there is ambiguity around whether patient-centeredness requires the active involvement of the patient in the reporting process. Gregory et al. (2014), discuss a didactic nurse-to-nurse, third-person bedside report style. Kullberg et al. (2018), suggest some nurses prefer the nurse-to-nurse approach, which negatively affects patient satisfaction due to the hierarchical nature of the report method.

**Provider Focused.** Information provided using traditional report methods appears to stem from provider driven goals for task completion (Athanasakis, 2013), biomedical data (Sarvestani et al., 2015), and provider-centered outcomes (Fealy et al., 2018). In fact, Sarvestani et al. (2015) observed only an average of 42 seconds per patient of actual patient-centered reporting was spent within the total 42-minute shift report time.

Compounding this, Wray et al. (2016) propose a conceptual model of reporting that focuses on "good physician-patient communication" (p. 679), but continue to support egocentric care provision by suggesting physicians should offer information about themselves through posters and face cards, despite later indicating that patients prefer face-to-face communication. And while Bressan et al. (2019) endorse patient-centered reporting, their five-step model supports patient inclusion at the end of the information exchange, rather than throughout the interaction.

**Restrictive mnemonics.** It appears the use of current reporting mnemonics, such as SBAR (Situation, Background, Assessment, Recommendation), largely influences patient-centeredness in a negative way. In this literature review, all models of reporting were shown to display a severe lack of active patient inclusion. Three articles referred to mnemonics as a means to shape the report structure. However, they provided mnemonics that did not consider

active patient inclusion in reporting (Fealy et al., 2018; Gordon et al., 2018; Sarvestani et al., 2015). Mnemonics focus strictly on the situation at hand and the action plans for care (Riesenberg et al., 2009). To support person-centered reporting, existing handover mnemonics must be revised or created to include the patient.

***Lack of Education.*** The largest barrier to conducting active person-centered reporting combines these afore mentioned sub-categories, knowledge deficit and methodology, to form the basis of the current inadequacies around the theoretical translation into practice. Various researchers describe a lack of education regarding handovers in health care curriculum (Athanasakis, 2013; Fealy et al., 2018; Gordon et al., 2018; Sarvestani et al., 2015). Athanasakis and Gordon et al., further describe a hidden curriculum within practice that is reliant upon ward culture, single-profession viewpoints, and situational context. Sarvestani et al. describe disagreements among professions about content, suggesting that the definition and resultant practice of person-centeredness remains heterogenous, if not ambiguous.

#### **Evidence Based Practice: Verification of Chosen Option**

The findings from this review of literature support the development of healthcare curriculum that substantiates person-centered care and provides instruction on associated practice methodologies. In contrast to hidden curriculum, formal curriculum is based upon theory that can be practically applied and allows for opportunities to evaluate learning. “Planned and guided by the school”, it provides a structured framework that follows practice competencies, is evidence informed, and therefore, unified in its content and delivery (Kerr, 1999, as cited in Kelly, 2009). Therefore, the purpose of the DNP project was to develop and implement a formal PCC curriculum module to be offered within a university NP program. The module provided clear definitions of PCC within the context of primary care and provided

education on a practical report method that supported the application of the concepts of PCC in clinical practice.

### ***Educational Intervention***

Specific guidelines for PCC exist worldwide which verified the need for this intervention and were used to develop the curriculum module. For example, in Canada, the Registered Nurses Association of Ontario (RNAO) created Person-and Family-Centered Care Clinical Best Practice Guidelines (2015). The National Institute for Health and Care Excellence (NICE), based in the United Kingdom, published guidelines around actively involving patients in their care (2012).

### ***Practice Intervention***

To date, there is no literature that supports the practice intervention-- a model of person-centered student-preceptor reporting for primary care settings. Therefore, a new model was introduced, termed by the DNP student as Second Person Reporting (SPR), unveiled from the hidden curriculum of practice. SPR requires the reporter to use second-person dialogue, speaking directly to the patient, with the person receiving the report listening in. Second person language uses the word *you*, rather than using pronouns (Surber, 2019), and therefore has an added benefit of being non-binary in nature.

SPR, although previously unnamed as such, is currently used when performing bedside rounds within some hospital settings, particularly within Accountable Care Units (ACUs) (Health Quality Council, 2017). ACUs are designed to conduct Structured Interdisciplinary Bedside Rounds (SIBR). Both concepts are the foundational works of Dr. Jason Stein (1Unit, 2019). The literature supports performing bedside nursing rounds, a practice that often includes the patient in the report process (Gregory et al, 2014; Lu, et al., 2014). Early outcomes of ACU and SIBR research is very promising, particularly when looking at patient and staff satisfaction regarding these practices (Gausvik, et al., 2015; Taylor, et al., 2017).



## Theoretical Framework

Theories provide the foundational ideas and concepts that drive our practice. For this project, two main theories were used. The first, Bandura's (1994) Self-Efficacy Theory, drove the "how to" of presenting an educational intervention to students (See Appendix B, Figure A1 for a diagram of this theory). Bandura's theory proposes that self-efficacy drives performance. To be self-efficacious, one must possess components of; a) *mastery* of experiences both past and observed, b) *social support* for one's capabilities to succeed, c) *efficacious outlook/visualization* and d) *stimulation* of physical and emotional state (Bandura, 1994).

The second, McCormack and McCance's (in press) Person-centered Practice Framework, provided the practice concept as well as goals and targets, micro to macro, from which to focus on (See Appendix B, Figure A2 for a diagram of this framework). The framework addresses the ambiguity around the definition of PCC in that it supports a relationship between one definition, *care of the individual*, and a second definition, *individualized care of the person*. Care of the individual is offered by providers at a micro level, which appear as petals of what is seemingly represented as a flower in the diagram. While individualized care is offered at a macro level by larger support services (the outer ring). These two concepts, when addressed separately, create diversity in the way care is provided. Connecting the concepts, where each part makes up a whole, causes personalized care to occur at all levels and fulfills the outcomes (center core). In this way, a culture of PCC blossoms (McCormack & McCance, in press).

While person-centered care focuses on the needs, values and goals of the individual, it is not a sustainable model of care if it continues to be left to individual practitioners to teach and implement. Applying both theories, curriculum is taught in a more structured manner while application of the content is evaluated by the impact of the concepts at each level. For example, when looking at the diagram of the framework (Appendix B, Figure A2), the micro level uses

concepts found within the petals and is provided at an individual, student level within the curriculum. The meso level combines the experiences of the student practice environment (green inner ring) with the student's growth that is obtained through self-evaluation (yellow outer ring). The macro level is the university, fostering the development of the curriculum as well as future projects and research.

### **Methods**

The project was a quality improvement project with a combined education and practice intervention. The convenience sample, an entire MN-NP second-year cohort (n=17), was enrolled together in two practice courses and one theory course, all 13-weeks in duration. The educational intervention was offered within the theory course, and the practice courses provided the setting for the practice intervention. Participants were given links to anonymous online pre- and post-intervention surveys and asked to complete a qualitative reflective writing piece specific to the quality improvement project.

### **Goals & Objectives**

The aim of the project was to translate the concepts of person-centered care into a tangible practice method to be used by student practitioners within a primary care setting. To support this, the project required the development of an educational module that targeted nurse practitioner students. This module was designed as a living curriculum, with an end-project goal for future sustainability and enhancement of the module. The primary intended outcome of the project was, after completing the online curriculum module, NP students would demonstrate increased knowledge and ability to perform PCC principles through the application of the SPR method in clinical practice.

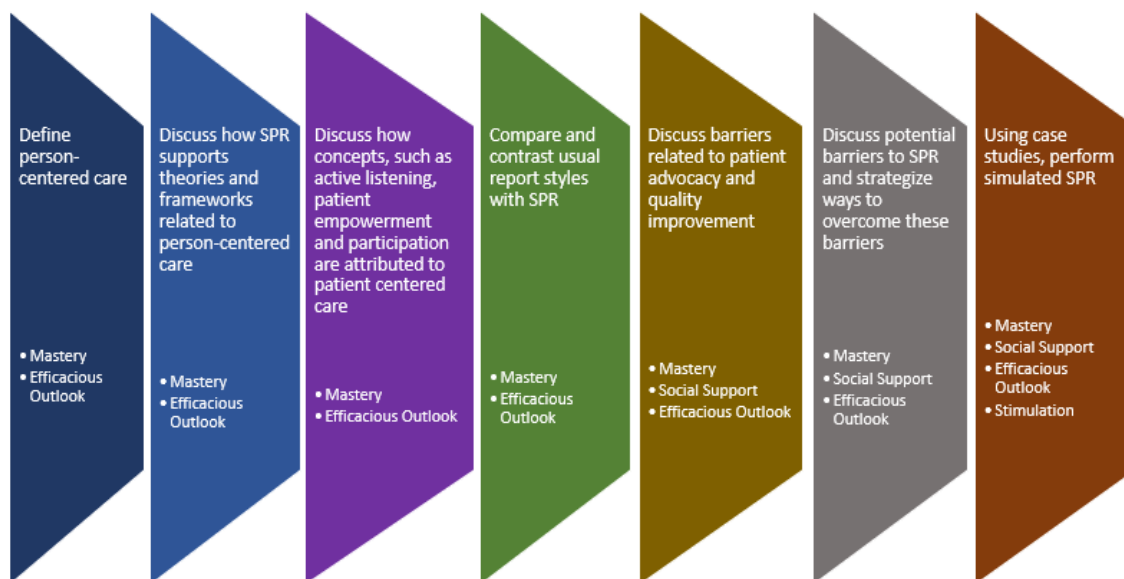
### **Educational Intervention**

The intervention consisted of a single one-hour virtual synchronous session using a platform students were familiar with. This session/learning module was provided to all students in the cohort at course mid-term, and was recorded for students to re-watch as desired. Slides from the module were also converted into PDF for students to download and write notes on.

The educational intervention was built using Self-Efficacy Theory components which were tied to the educational module's learning outcomes, as depicted in Figure 2 below.

**Figure 2.**

*Intended Learning Outcomes Related to Social Efficacy Theory*



The intended learning outcomes were also linked to all levels of McCormack & McCance's Person-centered Practice Framework (In Press). Using past and present experiences, students examine and enhance their own beliefs and values regarding person-centeredness (flower petals). As they imagine and discuss potential barriers to implementation, they consider organizational structures, role development, and the impact of PCC on the individual and culture, and how culture, and societal persuasion, impacts PCC. Practicing SPR allows students to not only increase their proficiency, but as they consider potential barriers, they begin to

understand the importance of advocacy and policy-making regarding patient preferences, clinic environment (micro level), appointment times and patient panel sizes (meso and macro levels), as a means to support PCC. By formalizing a report curriculum using a person-centered report method, the culture of person-centered care is born (center circle).

### **Practice Intervention**

During the first half of student practice, prior to the educational intervention, students reported to their preceptor using traditional methods; this allowed for students to get comfortable within their placement sites. Immediately prior to the educational intervention, students conducted a pre-intervention self-survey of their current reporting practices (Bandura, 1994).

At midterm, after the educational intervention, student participants were asked to perform the practice intervention for the remainder of their practice hours, whenever possible.

At the end of the practicum hours, students were asked to conduct a post-intervention self-survey of their report practice and submit a final written reflection on their education and practice specifically regarding the interventions. Students were asked to write about their perceived learning of the concepts offered within the educational module, their insights regarding SPR methods, confidence levels in performing SPR, and any reflections on the barriers they encountered and actions they took to address them. Again, this reflection was based upon the components of the Self Efficacy Theory, as well as Rolfe's reflective writing framework (2001).

### **Project Site and Population**

#### ***Site***

A Canadian University School of Nursing was the chosen host for this project. The educational intervention was delivered through the associated Master of Nursing, Nurse

Practitioner (MN-NP) program. The program requires students to complete 800 preceptor-led clinical practice hours over a two-year time period. Placement sites were located within primary and acute care health service locations throughout one province in Canada. These placements were where the practice intervention was conducted.

### ***Faculty***

NP faculty members were masters prepared Family NPs with 10+ years practice experience. The DNP student was a member of this faculty. In this program, faculty were responsible for curriculum and onsite development, teaching theory, attending site visits, teaching the practice curricula, marking assignments, monitoring and evaluating the students, and providing student feedback and preceptor support.

### ***Preceptors***

Student preceptors were NPs or family physicians with varied levels of experience in practice and preceptorship. This program provided preceptors with preceptor orientation packages prior to receiving students at their site. These packages consisted of information on student learning and competency requirements specific to the semester, as well as guidance around preceptor roles and responsibilities.

### ***Students***

Students within the MN-NP program had a minimum of two years recent registered nursing (RN) experience, current practicing RN licensure, and a minimum B+ average in their previous university level courses. The cohort consisted of male, female, and non-binary students with an average of five years varied practice experience that included hospital, community and remote practice. At the time of project implementation, student participants were entering into the fall (September-December) session of their second year of the two-year full-time program.

**Course**

At the time of writing, the School of Nursing MN-NP program delivered much of its content online through a variety of web-based synchronous and asynchronous learning tools. In addition, NP students were required to attend in-person skill-building instructional sessions. There were two practice courses for which the quality improvement project was implemented. The course for the educational intervention was a second-year theory-based course. The two clinical practice courses were combined, and therefore, hours were doubled during project implementation because of pandemic related practice restrictions from the previous term. Practice consisted of a minimum 250-hours, where students typically attended 8-hour shifts three days per week. The cohort was divided into three practice groups, each with their own faculty lead.

Prior to student placement, faculty contacted the preceptors to discuss semester learning goals and objectives, separate from the project. At that time, the DNP student provided further communication to all preceptors describing the project. At midterm, faculty performed student practice evaluations; the DNP student faculty member performed seven of these. Evaluations occurred over a period of two months. To maintain participant anonymity, at no point during the practice intervention was the project discussed with students or preceptors by any of the three faculty members (see section on Ethical Considerations /Protection of Human Subjects for further information).

**Measurement Instruments**

Both quantitative and qualitative instruments were used to measure DNP Project outcomes.

The Patient Perception of Patient-Centeredness Questionnaire (PPPC) by Steward et al., (2004), was adapted and used with permission from the Center for Studies in Family Medicine.

There were nine original questions in this questionnaire, with three additional project specific questions, created by the DNP student, related to report style (See Appendix C). The original questionnaire contained four answers to each question using a four-point scale. To reduce the potential for skewness, a third “neutral” answer choice was added to each of the questions to create a five-point Likert scale. The reliability and validity of the original nine-item, 4-point questionnaire is 0.79 n=117 (Steward et al.). The post-intervention survey had two answer choices to question 10 adjusted to “third-person” or “second-person.”

Students were asked to write about the education and practice intervention using Rolfe’s framework for reflective practice (2001), which prompts exploration into the “what, so what and now what?” of the theory and practice. The additional qualitative approach was chosen because this method allowed for the analysis of a deeper insights that would not likely have been obtained through quantitative analysis alone.

Themes from the qualitative data were extracted after all submissions were received and compared. Data from the Likert survey were matched and compared to pre and post intervention.

### **Ethical Considerations/Protection of Human Subjects**

Prior to initiating the project, the DNP student obtained Internal Review Board approval and Human Research Ethics Board approval from the DNP student’s university and project site respectively.

Informed consent was obtained from all students prior to project implementation. All participants were protected by Canada’s Freedom of Information and Protection of Privacy Act (FOIPPA), pursuant to sections 26-30.1, RSBC 1996, c. 165 (Queen’s Printer, 2020), which among other guarantees, protects participant’s privacy of personal information. No patient information was collected. Participation was strictly voluntary.

All information collected as part of evaluating the impact of this project was aggregated data from the project participants and did not include any potential patient or participant identifiers.

The dual-role power relationship between the DNP student as project lead/ faculty and the students as participants was mitigated by ensuring participant anonymity and confidentiality.

The risk to patients participating in this project was no different from the risks of patients receiving standard third-person student-preceptor report methods. Participant risks included the possibility of emotional or psychological discomfort, such as feeling inadequate or embarrassed due to undertaking a report style that was unfamiliar to them. Participants were advised to mitigate these risks by preparing for and practicing the intervention before conducting it in front of the patient. Participants were also advised of the inconvenience this project could have caused, particularly in relation to time spent completing the surveys and self-evaluation.

Participant identification was kept from the DNP student/university faculty member to ensure dual role power imbalance was minimalized, if not eliminated. Consent forms, and any electronic communication or data that contained identifiable information, was secured by the Survey Monkey program. The program was password protected. Data within the program and downloaded from the program did not contain identifiable information.

### **Data Collection Procedures**

All surveys were completed online using the data collection and analysis software *Survey Monkey*. This program provided anonymity through a secure platform that participants logged into, without having to provide any identifiable information. Data from both questionnaires was categorized into pre- and post- intervention data. Each question was



assigned a variable for a title, with the collated Likert responses to each question being entered into Excel and transposed into table format.

The participant self-reflection of this quality improvement project was written separately from their course-required reflection. This reflection was completed online via Survey Monkey with an additional component of a comment box being provided to complete the reflective piece. All written information was collated and responses to each question compared between respondents. Key words and ideas were extracted and considered “themes” if mentioned by more than one respondent.

### **Project Costs**

There were no financial costs for this project, as existing resources were used. Costs associated with time bore the greatest impact to the DNP student who served as project lead and participants (See Appendix D: Project Costs).

### **Results**

Using a combination of Excel and the Survey Monkey software, a descriptive statistical analysis was conducted to determine the extent to which the reporting framework influenced the application of person-centered care. There were 10 pre-intervention respondents and six post-intervention respondents. Of the 10 pre-intervention respondents, two were removed due to all responses being skipped. Of the six post-intervention respondents, one was removed due to all responses being skipped. Remaining responses were converted to numerical values, five being the highest-level answer (e.g., “Completely”), and 1 being the lowest-level answer (e.g., “Not at all”); these were entered into an Excel database and converted to a table format. Those values were used for calculating averages and percentage of pre to post-intervention change in the 12 measurable variables; the variables are listed below in Table 1 (See Appendix E for more detail on survey questions).

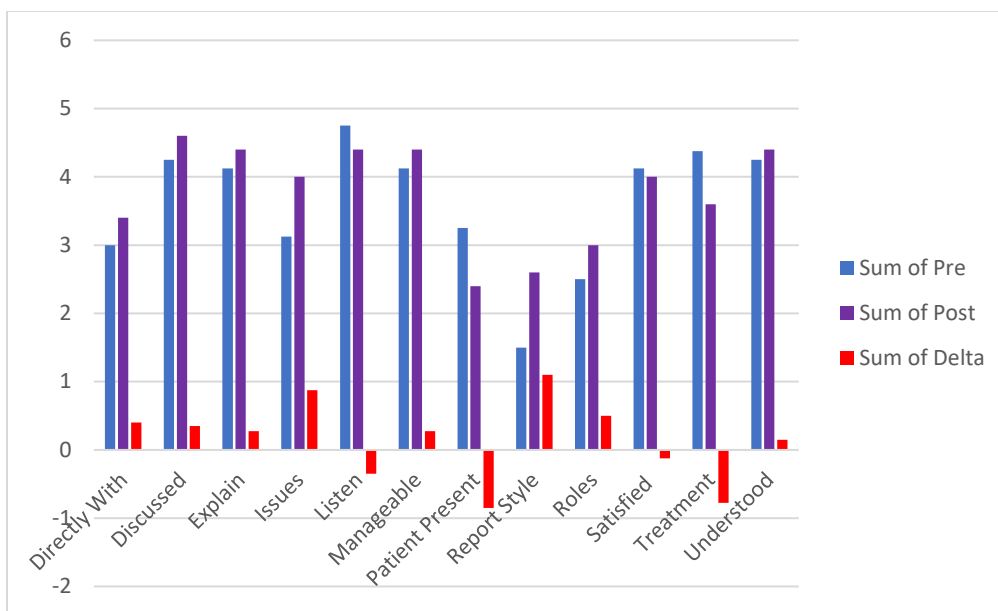
**Table 1.***Data Variables*

Extent of discussion	Problem explanation	Management	Patient present
Satisfaction of discussion	Role definition	Understanding	Participants
Listening	Treatment explanation	Personal issues	Report method

Variables, such as listening, understanding, discussing and explaining are foundational to the practice of person-centered care. Shared decision-making and acting authentically arise from these ways of being and impact the culture and practice of the individual, the profession, and the organization, coinciding with all levels of McCormack & McCance's Person-centered Practice Framework (In Press).

The bar graph below (Figure 3.) provides a visual of the results of both surveys. All but four variables were shown to have improved outcomes at the post-intervention. Although not clearly depicted in the graph below, SPR was only used by one respondent at the time of the post-intervention survey, suggesting it was not consistently used by all participants in the post-intervention period.

**Figure 3.***Summary of Pre and Post Intervention*



Sample size limited the ability to perform a robust method of qualitative analysis. Five respondents answered each of the text questions with varying degrees of depth and reflection. However, four responses were adequate for establishing three themes; (a) time (N=4); (b) preceptor support (N=3); (c) alternate settings (N=2), as discussed below.

### Discussion

The main goal of this project, to translate the concepts of person-centered care into a tangible practice method to be used by student practitioners within a primary care setting, was partially met. The method was endorsed by students and their preceptors as a means to increase one's ability to provide PCC, as evidenced in the qualitative feedback. Students described the value of providing report with the patient present, offering inclusivity, clarification, and educational opportunities. However, most continued to prefer to use traditional methods by the end of term, as a result of feeling inadequate, or unsupported by their preceptors who were unfamiliar with this report method. This pattern is consistent with the previous literature of Gregory et al. (2014), regarding how a lack of knowledge negatively impacts one's confidence in their ability to provide report with the patient present.

### **Setting, Facilitators and Barriers**

Facilitation of the project occurred at an organizational and personnel level. The university organization itself was conducive to supporting the education and practice intervention, as mentioned within the “Organizational “Gap” Analysis of Project Site” section of this paper.

There were five full-time faculty members within the NP program. Three full-time faculty members and one sessional taught the courses from which the project was conducted. Faculty members voiced support for this method of reporting. Interestingly, recognizing its applicability more so within an undergrad program. Some faculty voiced hesitancy in using this report method in primary care, stating time constraints and patient discomfort as potential barriers. This causes one to consider the effect of instructor (social) support on the method’s success. Being that SPR is a new method, instructors themselves must incorporate the components of Bandura’s Self-Efficacy Theory not only in their teaching of SPR, but also in their own ability to practice it.

Preceptors were either facilitators, antagonists, or neutral parties in the project. Report methods preceptors require of students is based upon preceptor preference. As such, preceptor support for this project was voluntary. Some preceptors were already performing a style of SPR, without having named it accordingly. Others were reported by participants to have held fast to the student-preceptor dyad and requested report be provided away from the patient.

Multiple barriers were encountered by participants when attempting to implement the report method, as outlined below. These barriers are all linked to one’s ability to be self-efficacious.

***Time and confidence, physical and social barriers.*** Students, and most preceptors, were assumed to be novice practitioners of this method (Bressan et al, 2019). Being novice, and

therefore lacking confidence, may have created time barriers, as the new report style requires one to be adept in leading purposeful, succinct communication. Three respondents cited the fast-paced nature of the practice causing preceptors to request brief reports away from the patient. Having to relay the report to multiple members of the team located apart from one another (e.g., pharmacy, social work, nursing staff) also prevented the use of SPR. Student practitioners felt pressure to give report directly to their preceptor, to allow time to relay report to other members of the team who were outside the immediate patient-provider circle. Support for SPR within a hospital setting was voiced by a participant, due to the ability to have all professions in one location at the bedside, and the potential to create the ability to allow for longer report times with patients. This feedback supports the need to repeat the project within a foundational registered nursing program using an alternate clinical setting.

Societal persuasion positively or negatively impacted participant's ability to perform SPR. While students are required to demonstrate competency in areas of leadership, advocacy and initiative, being novice, some students felt they were in a vulnerable position and voiced an inability to conduct the report in clinics where preceptors were not open to it. Other students felt supported using SPR and voiced the desire to continue this method in future practice. Highlighting to preceptors the importance of their role as promoters of inquiry and supporters of students as change agents (Benner et al., 2010) is an area to focus on for future success of the model.

Resistance to SPR by preceptors causes one to consider the effect of large patient panels and short appointment times on PCC. A fee for service model of care, most often used by physicians, influences these factors, as does the physician shortage and subsequent push to enhance NP rosters and reduce appointment times (Ryerson University, McMaster University, 2015). These factors would negatively impact the ability to offer SPR, giving cause to advocate

for smaller patient panels and longer appointment times, especially when managing complex patients.

**Participant anonymity.** The DNP student project lead found that anonymity of the participants kept the lead from being able to enact fundamental components of the Self-Efficacy Theory; modeling the behavior (observed experience) and offering social persuasion through coaching and feedback. Participants were unable to seek ongoing support, education, and motivation from the lead as expert. Had this been available, barriers of time and lack of confidence and discomfort with the new report method may have been reduced if support was ongoing. Consistent with the literature review, time constraints became less of a concern as comfort with the method increased (Athanasakis, 2013; Gregory et al., 2014; Hauer et al., 2010; Kullberg et al, 2018; Sarvestani et al., 2015). Thus, anonymity was a key factor in the goal of students increasing their ability to perform PCC reporting being only partially met.

**Patients.** One respondent stated the patient's themselves were a barrier due to their age or stage of development and associated lack of ability to contribute meaningfully. This brings to light the importance of including family/friends in the encounter, supporting Freidman's Family Nursing Theory (1998).

**Pandemic.** The Covid-19 pandemic created physical and emotional barriers to practice, again, impacting components of self-efficacy. Asking students to conduct a new practice method that is not a part of the required curriculum, especially under the stress of a pandemic, likely contributed to decreased participation (N=8), early participant withdrawal (N=3), and inaccurate or incomplete survey responses (N=2). Stress and feelings of being overwhelmed may also explain the drop in post-intervention survey completion.

The pandemic impacted practice through the introduction of never before used virtual patient visits. At times, up to one-quarter of student patient interactions were performed

virtually or through telehealth. Thus, the need for student-preceptor report was reduced, as the virtual interactions were already tripartite in nature.

### **Benefits**

All respondents mentioned SPR contributed to their ability to offer increased person-centered care, particularly through sharing ideas, reflecting and clarifying the patient's story. Therefore, the project goals of translating the concepts of person-centered care into a tangible practice method, and increasing participant knowledge of PCC, were met.

An unintended benefit came as a consequence of discussing the barriers to implementation. Students reflected on their own role regarding advocacy. For themselves, as they wanted to attempt practices that preceptors were unfamiliar with and therefore hesitant to embrace. And for the profession, as they looked to their part in enhancing the role, the scope and the practice of NPs in a way that supports PCC.

### **Inferences and Future Considerations**

While the data was evaluated to reflect the impact of SPR on PCC practices, there did not appear to be a substantial increase in SPR use during the post-intervention period; only one respondent reported using SPR on the date of the post-intervention survey, despite all post intervention participants (n=5) purportedly having attempted the method. Therefore, it becomes difficult to assess impact and make inferences to a larger population.

Despite this, variations between pre- and post-interventions were still appreciated, and must be noted, as one main observation makes for an alarming suggestion. Time, or more specifically, experience, became the dependent variable. The longer students were in clinical practice, thereby increasing their efficiency, *listening*, being *present with the patient* and *explaining treatments* declined, along with a decrease in satisfaction when discussing the patient's concerns. This suggests that provider proficiency or experience could negatively impact

our ability to provide person-centered care; experience equates to efficiency which equates to reduced patient interaction. Also, given that the qualitative feedback indicates traditional, third person reporting preferences of preceptors and associated fast-paced environment and preceptor expectation as barriers, one can note the negative effect the “hidden curriculum” has on learner’s practice.

Self-efficacy of PCC practices within the nursing profession, which includes mastery through experiences, social persuasion through coaching and feedback, the ability to visualize the action and consider the emotional and physical impact on ability, is foundational to the practice of caring. Providing a curriculum that teaches students using Bandura’s (1994) Self-Efficacy Theory as a guide, supports the ability to translate person-centered theories into action. As such, SPR is likely to be best offered in RN undergrad programs within a bedside report environment, as survey respondents suggested, so that PCC practices adopted at a foundational nursing level are then built upon in higher-level nursing programs. New graduate nurses will start their careers with the understanding of the theories of PCC, the confidence, and the skill to perform person-centered report methods, such as SPR, through learning within a structured, supportive environment. Nurse practitioner students, having obtained this experience in their undergrad, would then be able to adapt the bedside report to a primary care setting. Past experience with this model would aid in reducing the time and confidence barriers that were evident in this project and found in previous studies regarding bedside reporting (Fealy et al., 2018; Gordon et al., 2018, Gregory et al., 2014). With the support of instructors and a practice environment that upholds a culture of PCC, novice nurses will spearhead a change in the provision of care. By acting as role models to senior nurses, nurse practitioners and physicians who have not received this formal education, nurses will offer a more patient centered report style that currently is lost to time and the pressures of efficiency.



## Conclusion

Until now, patient-centered theories had yet to have been translated into student-preceptor report practices. This gap in practice stems from a deficit in the provision of formal education within healthcare programs, and from the lack of a report method that incorporates person centeredness. The provision of a curriculum that translates PCC theories into practice, supports government and organization's goals of healthcare reform toward more person-centered practices (British Columbia Ministry of Health, 2015; WHO, 2015). Formalizing the curriculum and teaching SPR, a report method that specifically enacts PCC, will aid in ensuring the current outdated paternalistic report methods taught within the "hidden curriculum" of practice are phased out.

This DNP capstone project addressed the gap between the theory and practice of person-centered care through the implementation of a quality improvement project that provided formal curriculum and practice opportunities to one cohort within a university nurse practitioner program. Results of the project suggest there is a place for SPR in clinical practice. Future project development and implementation within an undergrad nursing program should be considered. More advocacy is required around maintaining a culture of PCC, and that starts with endorsing suitable length of patient appointment times which will allow for increased preceptor support of students as change agents. Of course, no person-centered practice method is complete without patient input. More research is required to determine how this education and practice intervention impacts patients as well as providers.

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## Appendix A

*JHNEBP Assessment of Included Studies Matrix*

CITATION	AIM	METHOD	SAMPLE SIZE	*STRENGTH & QUALITY	KEY POINTS
Athanasakis, (2013)	Evaluate the evidence around issues concerning nursing handovers	Literature Review	19 articles 2000-2012	V, B	<ul style="list-style-type: none"> <li>-Increased safety and satisfaction</li> <li>-Task oriented</li> <li>-Nurse driven report</li> <li>-Hidden curriculum</li> <li>-Variable approach</li> <li>-Decreases time</li> <li>-Bedside Reporting</li> </ul>
Bressan et al. (2019)	Acquire understanding of patient experiences regarding bedside shift report	Systematic Review & Meta-synthesis	10 articles all before August 2018	IV, B	<ul style="list-style-type: none"> <li>-Increased safety and satisfaction</li> <li>-Flexible approach to pt. inclusion</li> <li>-Reporter insecurities/fear of lack of knowledge</li> <li>-5 step method</li> <li>-Jargon a barrier</li> <li>-Patients get to know RN scope/appreciate nurse</li> <li>-Humanizes the patient</li> <li>-Bedside reporting</li> <li>-Increases time spent with nurses (positive)</li> </ul>
Fealy et al. (2018)	Identify resources and supports to enhance handover, identify barriers and facilitators of handover	Qualitative Focus group using inductive analysis	116 healthcare professionals from 12 urban and regional hospitals 28 interviews 13 focus groups	III, A	<ul style="list-style-type: none"> <li>-Poor handover impacts safety and communication</li> <li>-Institutional policies exist, staff not aware of policies</li> <li>-Poor training</li> <li>-Recommendations to improve handover do not include PCC</li> <li>-Mnemonic</li> <li>-Handover occurred in person, away from pt. resulting in many negative aspects (increased time, poor documentation, task oriented, interruptions)</li> <li>-Bedside handover was suggested for improvement</li> </ul>



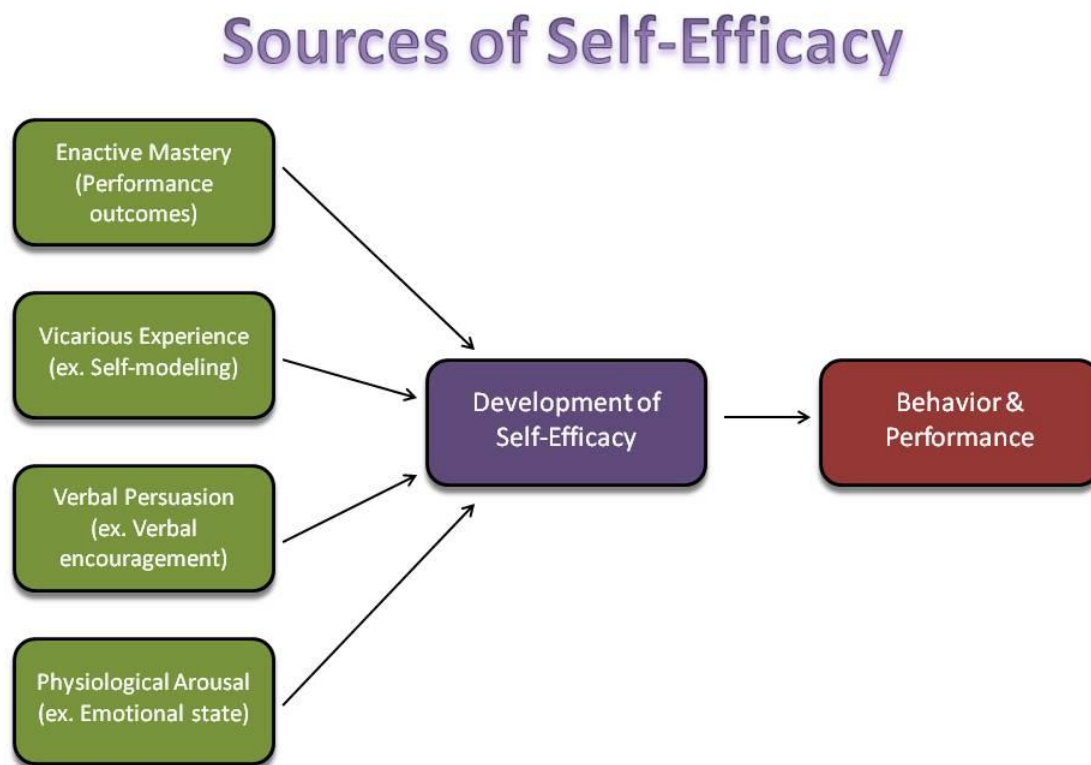
Gordon et al. (2018)	Investigation of educational interventions	Systematic Review	18 articles 2010-2016	IV, B	<ul style="list-style-type: none"> <li>-Increased safety and satisfaction</li> <li>-Flexible approach to pt. inclusion</li> <li>-pedagogy lacking</li> <li>-Increases time</li> <li>-Mnemonic approach</li> </ul>
Gregory et al. (2014)	Looks to BSR to improve quality, patient safety, PCC	Systematic Literature Review	33 articles no date range	IV, A	<ul style="list-style-type: none"> <li>-Increased safety and satisfaction</li> <li>-Didactic reporting</li> <li>-Decreases time</li> <li>-Lack of nursing confidence</li> <li>-Bedside reporting</li> </ul>
Hauer et al. (2010)	Assess whether students use of SDM correlates to SP ratings of their communication	Retrospective Study, Quantitative	779 decision moments analyzed	III, A	<ul style="list-style-type: none"> <li>-Increased pt. satisfaction</li> <li>-Time constraints, decreases</li> <li>-Novice ability</li> <li>-OPTION scale to assess SDM in practice</li> </ul>
Kullberg et al. (2018)	Describe RN perspectives of PCH	Qualitative Interview Study Semi-structured interviews	11 RN sample size	III, C	<ul style="list-style-type: none"> <li>-Increases safety and pt. satisfaction</li> <li>-Decreases time</li> <li>-Flexible approach to pt. inclusion</li> <li>-Variable methods, primarily task oriented</li> <li>-Staff insecurities about knowledge increased preparation</li> <li>-Nurses perceive pts holistically</li> <li>-Bedside reporting</li> </ul>
Oswald et al. (2014)	Students reflections on patients as educators	Qualitative Analysis of writing	356 writing assignments analyzed	III, A	<ul style="list-style-type: none"> <li>-Pts as teachers, team members, humans</li> <li>-Student understanding of role complexity</li> <li>-Avoid jargon</li> </ul>
Sarvestani et al. (2015)	Explore challenges of BSR	Qualitative Descriptive exploratory Inductive approach	14 handover reports 130 patient reports	III, C/B	<ul style="list-style-type: none"> <li>-Increased safety and satisfaction</li> <li>-Unclear on pt. inclusion in method</li> <li>-Decreases time</li> <li>-Lack of Pedagogy</li> <li>-Mnemonics</li> <li>-Task oriented</li> <li>-Biomedical</li> </ul>

					<ul style="list-style-type: none"> <li>-Non-holistic approach resulting in</li> <li>-Lower ethical content</li> <li>-Jargon</li> <li>-Bedside reporting</li> </ul>
Wray et al. (2016)	Describe hospitalized pt experiences regarding physician handoffs	Qualitative, semi-structured interviews	43 participants	III, B	<ul style="list-style-type: none"> <li>-Increased safety and satisfaction</li> <li>-Financially driven need for physicians to provide PCC “good” communication physician centered</li> <li>-Patient is primary stakeholder in handover</li> <li>-dissatisfaction with redundant communication</li> <li>-provider focused care model despite pt. preference for pt. interaction</li> <li>-Bedside reporting recommended</li> </ul>

\* Johns Hopkins Nursing Evidence-Based Practice Rating Scale: Newhouse, R., Dearholt, S., Poe, S., Pugh, LC., White. K. (2005). The Johns Hopkins Nursing evidence-based practice rating scale [PDF file]. Baltimore, MD. The Johns Hopkins Hospital; Johns Hopkins School of Nursing.  
<https://www.mc.vanderbilt.edu/documents/CAPNAH/files/Mentoring/Section%206/JHNEBP%20Evidence%20Rating%20Scale.pdf>

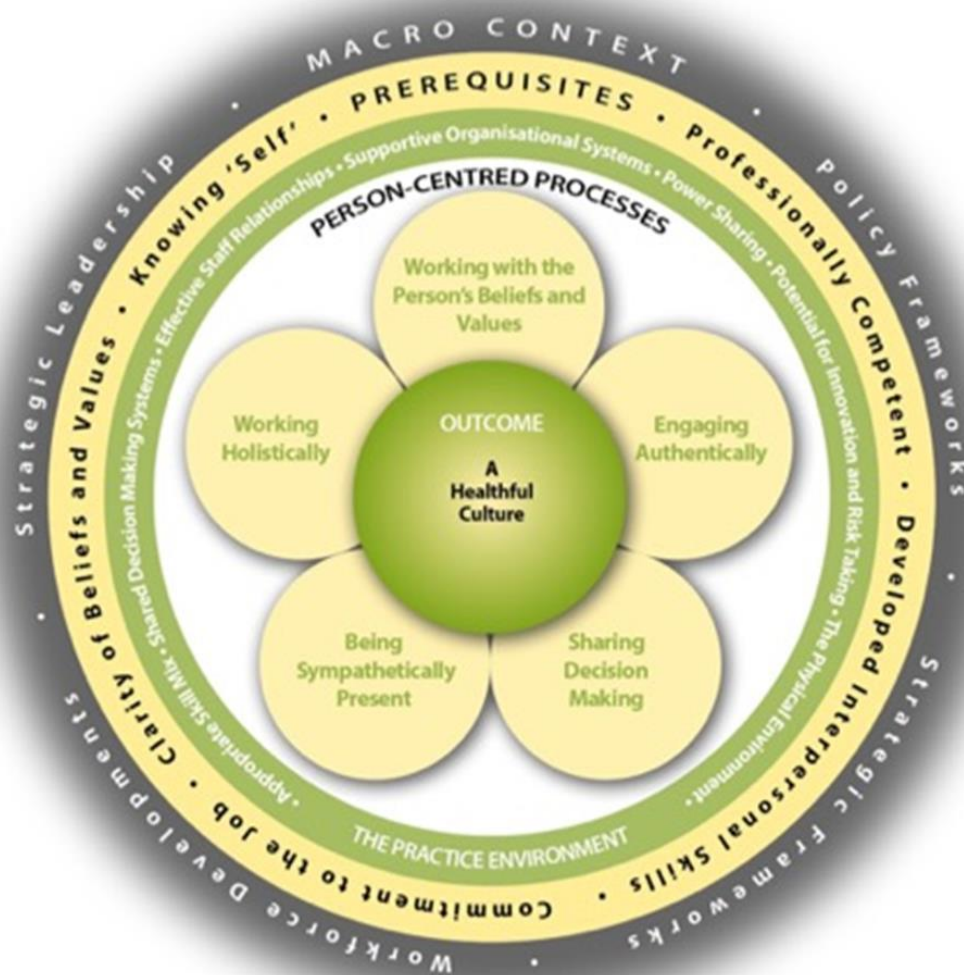
## Appendix B

Figure A1.

*Bandura's Self-Efficacy Theory*

Source: Danielle Lee Novack, Self-Efficacy Case Study. (2013). Retrieved from <https://wikispaces.psu.edu/display/PSYCH484/Fall+2013+Self-Efficacy+Case+Study>

Figure A2.  
McCormack & McCance's Person-centered Practice Framework



Source: McCormack, B and McCance T.V. (in press). The Person-centered Practice Framework 2017. [revised] Fundamentals of Person-centered Care. Wiley, Oxford

## Appendix C

## PPPC Questionnaire/Survey

Please select the answer that best represents your response:

- |   |               |                 |                    |               |
|---|---------------|-----------------|--------------------|---------------|
| 1. To what extent was your patient's main problem(s) discussed today?   |               |                 |                    |               |
| Completely  | Mostly        | Neutral         | A Little           | Not at all    |
| 2. How satisfied were you with the discussion of your patient's problem?  |               |                 |                    |               |
| Very Satisfied  | Satisfied     | Neutral         | Somewhat Satisfied | Not Satisfied |
| 3. To what extent did you listen to what your patient had to say?   |               |                 |                    |               |
| Completely  | Mostly        | Neutral         | A Little           | Not at all    |
| 4. To what extent did you explain the problem to the patient?   |               |                 |                    |               |
| Completely  | Mostly        | Neutral         | A Little           | Not at all    |
| 5. To what extent did you and the patient discuss your respective roles?<br>(Who is responsible for making decisions and who is responsible for what aspects of your care?) |               |                 |                    |               |
| Completely  | Mostly        | Neutral         | A Little           | Not Discussed |
| 6. To what extent did you explain treatment?  |               |                 |                    |               |
| Very Well   | Somewhat Well | Neutral         | A Little           | Not at all    |
| 7. To what extent did you and the patient explore how manageable this (treatment*) would be for the patient? We explored this...  |               |                 |                    |               |
| Completely  | Mostly        | Neutral         | A Little           | Not at all    |
| 8. How well do you think you understood the patient today?  |               |                 |                    |               |
| Very Well   | Somewhat Well | Neutral         | A Little           | Not at all    |
| 9. Regarding today's problem, to what extent did you discuss personal or family issues that might be affecting your patient's health?                                       |               |                 |                    |               |
| Completely  | Mostly        | Neutral         | A Little           | Not at all    |
| 10. Please describe the student-preceptor report framework you used:  |               |                 |                    |               |
| Mnemonic (i.e., SOAP)   |               | Narrative style |                    |               |
| 11. Was the report provided with the patient present?   |               |                 |                    |               |
| Completely  | Mostly        | Neutral         | A Little           | Not at all    |
| 12. If the patient was present, how often did you discuss your report directly with the patient?  |               |                 |                    |               |
| Completely  | Mostly        | Neutral         | A Little           | Not at all    |

Adapted and used with permission from: Steward, Meredith, Ryan & Brown, Centre for Studies in Family Medicine. (2004). Working paper series. Paper #04-1. The patient perception of patient-centeredness questionnaire. The University of Western Ontario. London, Ontario Canada.

## Appendix D

*Project Costs***Start-up Costs (DNP student hours @ no financial cost)****Preparation**

Gathering and or creating educational media for curriculum module: the “why and how” of the project, such as power points, videos that describe the process, literature review 8 hours x 20 days

Development of online surveys/reflection and preceptor introductory letter 16 hours

**Total preparation time: 176 hours**

**Data collection (Participant hours @ no financial cost)**

Data collection	Time in minutes	Cumulative total (per participant)
Pre-intervention survey (N=8)	5	5
Post- intervention survey (N=5)	5	10
Final self-evaluation (N=4)	10	20

**Total participant time: 1:35 hours**

**Data analysis (DNP student hours @ no financial cost)**

DNP student data entry and analysis 8- hour days x 2 days= 16 hours

**Total analysis time: 16 hours**

**Project write-up (DNP student hours @ no financial cost)**

Compile, draft, final write- up 8-hour days x 21 days= 168 hours

**Total project write-up time: 168 hours**

**TOTAL PROJECT COSTS Financial: 00.00**

**TOTAL PROJECT COSTS Time: 361.35 HOURS**