Acute Care of the Elderly Column

Nurses’ impact on the hospital environment: Lessening or contributing to the chaos?

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1. “How does the patient know who is the nurse?”

Nurses visiting from Europe recently asked this question when standing on a general medical surgical unit surrounded by a number of individuals garbed in a plethora of colored uniforms. As we looked around, we noted what they must have viewed as chaos. Nurses, assistants and therapists wore a variety of colors for their uniform tops and pants, frequently not matching. Further, badge names were difficult to discern. This innocent question made us consider in what ways nurses contribute to the confusion in the hospital environment, either by what we do or don’t do. For this column, we’d like to focus on four areas under nurses’ control that may contribute to cognitive function or dysfunction in our older patients: identification of the nurse, maintaining orienting information in the room, consistent use of glasses and hearing aides, and noise control.

2. Identification of the nurse

Personnel are an important and ever present component of the hospital environment. Numerous personnel enter the patient’s room daily: nurses, nurse assistants, physicians, physician assistants, nurse practitioners, housekeepers, dietary aids, therapists, social workers, case workers, and so on. Decades ago, each role had a distinct uniform or requirements for business wear. At a glance, the patient often knew the role of the individual. Why is this important? From the patient perspective, knowing the role of the individual provides an important grounding for expectations. Uniforms assist not only in proper identification of the nurse, but can also inspire confidence. For older adults, white is the preferred color to distinguish the licensed nurse.1,2 Regardless of color, presence of an identifiable uniform results in higher ratings of nurses’ competence and professionalism.1,2 For the nurse and the organization, this can have important implications. The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey is a national, standardized survey of patients’ perspectives of their hospital care (www.hcahpsonline.org/home.aspx). Hospitals are required to collect, submit and publicly report their data. Failing to do so or failing to maintain quality scores may result in a significant financial penalty from the Centers for Medicare and Medicaid. Three of the HCAHPS questions pertain specifically to nurses: how often nurses treat the patient with courtesy and respect, how often the nurses listened to the patient carefully, and how often nurses explained things. Now consider your environment and whether a patient or visitor can easily distinguish the nursing staff from other personnel. We contend that the less able a patient or family visitor can identify the nurse, the more likely these questions will be answered based on interactions with any hospital personnel, not just the nurses. As the public becomes savvy in reviewing public report cards of hospital outcomes, it is unlikely an individual would willingly choose to go to a hospital where nurses didn’t explain things, listen closely or failed to treat the patient with respect and courtesy. Hence, the issue of whether to wear a uniform that is truly uniform (no pun intended) has significant ramifications for the patient, the nurse, and the hospital.

3. Maintaining orienting information in the room

This section will focus on three room items that nurses can impact: whiteboards as a communication tool, clocks, and calendars.

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0197-4572/8 – see front matter © 2013 Mosby, Inc. All rights reserved.
http://dx.doi.org/10.1016/j.gerinurse.2012.12.001
3.1. Whiteboards

In 2002 the Joint Commission launched a national campaign urging patients to take an active role in their care to prevent healthcare errors. The Joint Commission also requires the organization to encourage the patient to be an active participant in his care. There are a variety of ways organizations approach this, but one common modality is the use of dry erase whiteboards. Nursing personnel are typically responsible for the accuracy and updating information. From personal experience as an inpatient (LM), our clinical observations at several hospitals, and publications, a common issue that arises with the whiteboards is the lack of updated or accurate information. For instance, on Monday the primary day nurse could enter the date, her name and name of the nurse assistant. If the whiteboard is not updated, the patient will have the wrong information for day and personnel. At North-Shore-Long Island Jewish Hospital, whiteboards were instituted across their 15 hospital network; their advice: ‘it’s better to have no whiteboard than to have one that is not used or updated regularly.3

The lack of updates may be because no one takes responsibility, lack of pens, lack of time, or lack of perceived need.3 A unit-based practice committee could easily determine a unit-system for a) determining who should have the primary responsibility for daily updates, b) who and how often to monitor compliance and completion, and finally c) ensuring accessibility of working pens. For example, the day shift primary nurse starts the update but modified as necessary by subsequent shift nurses. The charge nurse (or assistant nurse manager or nurse manager) could be the person responsible to conduct daily patient rounds that includes monitoring of the whiteboards. Last, the unit secretary on night shift would ensure working pens in each room prior to leaving at the end of the shift. In addition to maintaining accurate and updated information, determining what information to include can vary by unit. Interdisciplinary practice improvement committees could determine whether to include daily goals, scheduled appointments, or anticipated discharge dates. If daily goals are included, whose goals should be addressed? Sehgal and colleagues3 point out the varying perspectives of patients, families, physicians, nurses, therapists, and nutritionists. Consensus among the various parties is needed if we wish to make this communication an effective strategy to engage our patients and families.

3.2. Clocks and calendars

Similar to whiteboards, who is responsible for ensuring accuracy? A number of years ago when training a high school student HELP4 volunteer, he observed a patient’s clock was not working. A work order was submitted that day to maintenance. When the student returned the following week, the clock had still not been repaired. If daily tear off calendars are in the room, these need to be checked each day. These may seem like simple issues, but as often as not, are overlooked in our busy environment.

4. Ensuring vision glasses and hearing aides are being used

As nurses we are often limited in the tools we can provide to patients to improve their hospital stay. One aspect for our aging population is the dilemma of not having the appropriate hearing aides or glasses. Our population is aging and becoming increasingly frail and with that comes increased rates of sensory impairment. The prevalence of hearing impairment among people over the age of 70 is 26.3% and vision impairment of those over the age of 70 is 15.4%. Moreover, both hearing and vision impairment double once you are over the age of 80.5 Between 60–70% of these patients could benefit from either glasses or hearing aides and often times when they are admitted to a hospital setting they either did not bring their assistive devices or do not have any. One concern that family members and patients often have is that their aide will be lost during their acute care stay and hence reluctant to bring them from home. There are two possible resolutions for these issues: developing a unit-based protocol for preventing loss of personal assistive devices and requiring the use of assistive devices that are available. This accommodation is now part of the Joint Commission accreditation standards in the Patient Communication section.

Ensuring good visual acuity as well as hearing is imperative to reduce complications or unwanted events, such as delirium and falls. Providing the needed assistive devices can often reduce agitated behaviors in an already delirious patient. Assistive devices purchased for a unit can include multiple pairs of varying strengths of bifocals or even a magnifier page. It is important to know if eyeglasses brought in by the patient are for distance (wall clock, TV, whiteboard), for reading, or both. Label the glass case so all will know. Another excellent but slightly more expensive option for hearing impairment would be a pocket talker/listener that has disposable ear covers to allow reuse between patients. A unit-based system would need to be in place for these devices as well: storage, retrieval, cleaning and return. For patients with sensory assistance devices in their possession, a unit-based system should be explicit that assists in caring and monitoring the items. The items should be documented as being present and a place for safekeeping in the patient’s room identified. Boxes for safekeeping can be purchased as well. Some units have added cradles or boxes affixed (via glue or Velcro) to the side table top or in the top drawer that are meant only for aide storage. The whiteboard could be used to document presence of hearing aides or glasses. At every shift a nurse can ensure that the item is present and being used if able. It is important to identify with every transition in care the location of the item and if it should be kept with the patient/family or in the identified unit storage location. If we are better at protecting the personal items it will save time spent looking for the item and improve the quality of the patient’s stay. The HCAHPS listed earlier in the column can also be improved by the utilization of assistive sensory devices. Our patients need to be able to hear and see us and if they are unable to we need to develop a method for communicating effectively.

5. Excessive noise

“Unnecessary noise is the most cruel abuse of care which can be inflicted on either the sick or the well.” (Florence Nightingale, Notes on Nursing, 1859). This issue is as true today as it was over 150 years ago. Indeed, hospital noise levels have increased substantially since 1960. Collaborators in The Nurses Improving Care of Hospitalized Elders (NICHE) listserv commonly raise the issue of how to reduce or minimize excessive noise. Excessive noise is known to by physically and psychologically harmful to patients and staff, reduce healing, and increase errors.7,8 Strategies to reduce noise include changes to the physical environment, such as sound absorbing ceiling tiles or carpeting, but also changes in staff behavior and routines. Excessive noise is a major patient dissatisfier and staff voices rank as among the most bothersome. Dube and colleagues9 outline a standardized approach to examine noise sources on one’s unit and design strategies to minimize them. Some strategies proved quite simple and inexpensive. For example, dimming lights at night resulted in people talking softer. Turning down ringer, eliminating over-head pages, and installing quieter paper towel dispensers in rooms all helped to reduced noise levels. The 57 patient care units varied in noise sources and subsequently some of the
interventions varied. Thus, each unit needs to carefully examine sources of noise, determine noise controlling interventions, and regularly monitor noise levels. Interdepartmental collaboration is necessary. For example, at our hospital environmental service personnel mopped and buffed the floors at night when foot traffic was lowest. The machines were so loud that patients were awakened. Once environmental services personnel were engaged in the noise reduction quality improvement plan, they quickly identified other times of the day that would be conducive to cleaning the floors.

6. Take home message

Never underestimate the power and influence that you as the nurse have on the hospital environment. Paying attention to the small things is as important as major renovations. Remain vigilant as to how the environment can enhance older adults’ function or contribute to adverse events and ways that we can address and promote a safer more therapeutic environment. We have focused on just a few aspects to begin discussions. For those interested in a more in-depth review of the hospital physical environment, the article by Ulrich and colleagues is an excellent resource.10

References