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Clinical Chatter: Every Nurse Informed

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ORIGINAL ARTICLE

‘Clinical Chatter’: every nurse informed

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Aims and objectives. To assess the acceptability and usability of a standardised communication tool for nurses.

Background and significance. Communication is key in health care. On a daily, if not hourly, basis, nursing staff is inundated with new information regarding tools and resources, practice changes and the work environment. However, there is currently no standardised messaging or delivery method to effectively communicate new information. Even with a plethora of communication tools such as flyers, posters, emails, unit huddles and unit meetings, there is no means to guarantee attendance to crucial information.

Design. Descriptive, cross-sectional online survey, implemented at a nonacademic, suburban hospital with 280 nurses.

Methods. The Clinical Chatter, an online tool developed by nursing leadership to standardise messages regarding the organisation, new tools and resources, professional development, recognition and unit updates, was delivered to each nurse on a weekly basis followed by administration of Acceptability and Usability scales.

Results. The Clinical Chatter tool has adequate acceptability and usability as a method of communication among nurses in a hospital organisation. Sociodemographic variables of age and years of experience had no statistically significant association with perceived acceptance and usefulness of the tool.

Conclusion. The findings indicate that the Clinical Chatter tool can be used as a standardised communication tool to deliver key information among nurses working in a hospital organisation. Nursing leadership must establish and support a clear communication system to enhance patient care and outcomes and improve nursing job satisfaction.

Relevance to clinical practice. Communication is vital to advancing health care. Lack of communication among nursing has been linked to unsafe patient care: medication errors, unhealthy work environments and decreased nurse retention rates. Clinical Chatter is an effective communication tool for presentation of institutional information to nursing personnel.

Key words: communication, electronic, leadership, nursing, organisation, standardised

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What does this paper contribute to the wider global clinical community?

- Organisation wide communication with nursing staff.
- Standardisation of information communication.
- Ensures every nurse receives uniform information across units within an organization.

Introduction

Lack of communication in health care and more specifically among nurses has been linked to unsafe patient care: medication errors, unhealthy work environments and decrease in nurse retention rates. It is vital that nurses are able to have open communication regarding not only the care provided to patients, but also work environment. Communication is a critical component of the daily work routine on the part of front line nursing staff, with nursing personnel unaware of the frequency with which communication occurs. Yet, while communication across several media platforms is a commonplace event in the clinical setting, often the ability to deliver focused institutional content is lacking. An institution often needs to communicate regarding continuing educational opportunities, unit-based updates and other information along with policy and procedural updates. To achieve this purpose, a number of approaches have been employed in the clinical setting, the postings of signs in select locations, the distribution of written materials and the provision of direct inservicing. However, these methods may not reach all staff members, and the content delivery can vary. Thus, providing a consistent means of reliable institutional content delivery to clinical nursing personnel in healthcare organisations in the United States communication remains problematic (Attree 2007, Institute of Medicine 2010).

Background

According to the United States Department of Labor, there are more than 2.7 million nurses currently employed across the nation (Bureau of Labor Statistics 2014). Nurses have the important role of being a patient's care provider, educator and advocate. It is critical that nurses stay informed and in constant communication with the healthcare team to deliver excellent care. 'When nurses practice in environments with good communication, adequate resources, and realistic patient responsibilities, the art and science of nursing is exhibited' (Amer 2013, p. 2). Yet, Malloy *et al.* (2009) determined, after a four-nation study, that nurse's felt that the system, physicians and patients and families silenced their voices. As a result of attention paid to this issue, an increased focus has been placed on nursing communication with other healthcare providers and patients. Numerous studies were conducted on communication between team members, with one result being an increased sense of engagement and self-efficacy on the part of nursing personnel (Garon 2012). In spite of these advances, there has been a dearth of research on methods of

communication between organisational layers within the nursing care setting.

Regardless of the background of a particular organisation or business, there is a tendency to use existent communication techniques or procedures, even if such are not efficacious in content delivery. Revision methods of communication are often considered to be expansive and require a great deal of effort with an uncertain outcome as to the effectiveness of the new procedures. 'Defenders of the status quo frequently cite the cost and effort associated with making a change while failing to recognise there are costs and missed opportunities associated with maintaining the status quo' (Henriksen & Dayton 2006, p. 1545). The organisations of the healthcare industry are not immune to this trap and often fall into it where communication is concerned. It has long been the structure of nursing in such healthcare organisations to have a hierarchy of communication consistent with their leadership model. First, the administration communicates with its nursing leadership team (manager and directors). Second, the nursing leadership team communicates with their specific unit's leadership teams, (educators, coordinators and assistant managers). Finally, the unit-specific leadership team communicates with the individual bedside nurses. Indeed, it can appear much like the childhood game of telephone, and indeed, the outcome is often of that of the game. In this case, the person who is directly impacting the care of the patients at the bedside is the one receiving an incomplete and distorted message critical to practice and excellent patient outcomes.

Problem statement

Nurses are in profession in which change is a constant. Changes in policies, bedside practice and technology are ongoing. Yet, all have the same goal of increased positive patient outcomes. Providing seamless open communication to those at the bedside is fundamental to increasing change awareness and decreasing rumours and lack of adherence to the change. To achieve these changes and ensure an organisation as a whole is working towards the same goal of excellent patient outcomes, communication must be consistent and reliable.

The manner, in which nurses are currently receiving updates and information critical to the performance of their job, is in practice, inconsistent. Communication is being delivered via flyers posted on units, monthly unit meetings, along with emails from the system, administration, unit-specific managers and interdisciplinary personnel. There is not one consistent information delivery method currently in

place to ensure that every bedside nurse has up-to-date information necessary to provide excellent patient care.

Purpose of study

The purpose of this study was to evaluate the effectiveness of a new communication tool and assess the acceptability and usability of a newly developed 'Clinical Chatter', a standardised electronic communication tool that facilitates routine dialog and ensures nurses are consistently informed of the most concise and up-to-date information to perform their job.

Clinical questions

- Was Clinical Chatter an acceptable method of routine communication for nurses?
- Was Clinical Chatter a usable method of routine communication for nurses?

Conceptual framework

The Leader Member Exchange Theory provided the conceptual framework of this study. This theory focused on the interaction between leaders and members or those they lead. Working to create relationships built on respect and trust through increased interfacing among leaders and members (Gupta 2009). Therefore, communication is one of the main factors in producing a positive leader-member exchange. Moreover, a study found that higher quality leader member exchange relationships could lead to overall positive outcomes for leaders, followers, work units and the organisation (Graen & Uhl-Bien 1995).

Literature review

The literature was reviewed to determine best practices in healthcare specific to communication within nursing. Computerised database sources included PubMed and CINAHL, and search parameters included were hospital administration AND communication [MeSH] AND nurse* [MeSH], organization AND communication [MeSH] AND nurse* [MeSH] and communications AND nurse* [MeSH] AND huddle*. The search was confined to the years, 2005–2015. As shown in Fig. 1, the investigator conceptualised there is a pronounced need for communication within nursing to flow from the organisation level down to the department level. How that communication should take place has not been standardised in practice.

Perception of communication

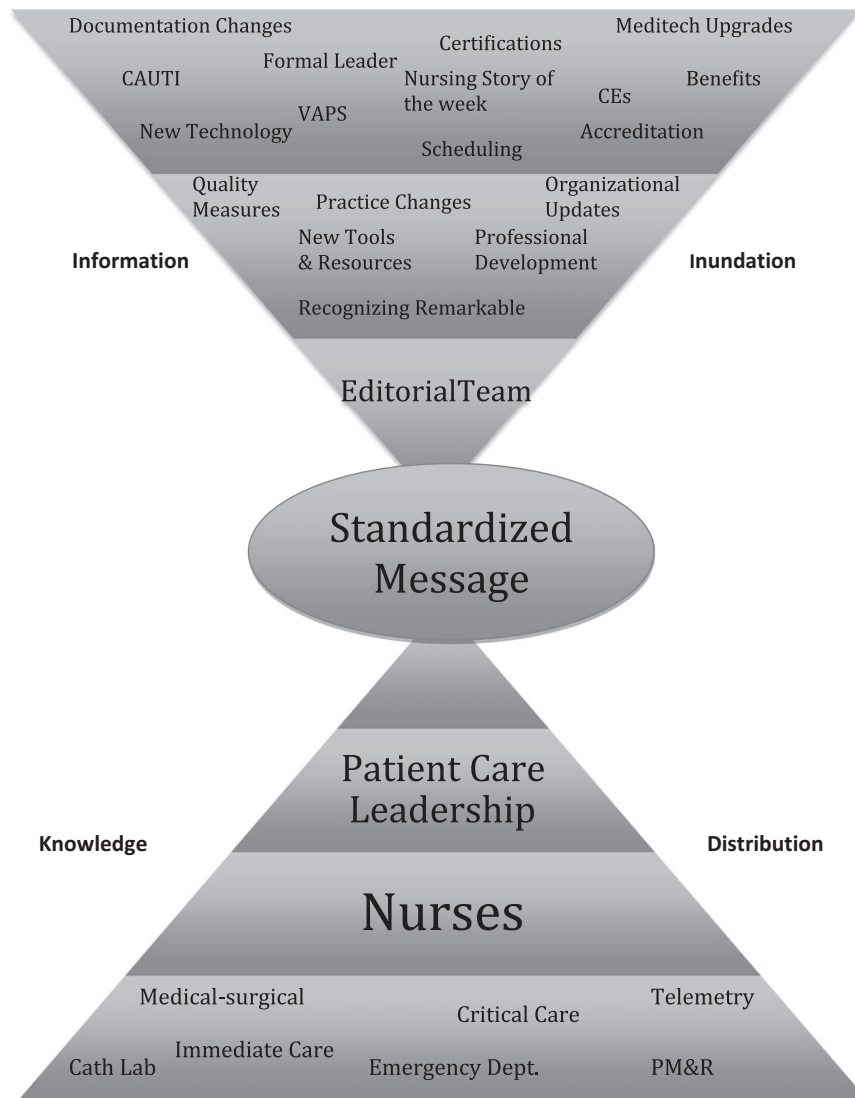
An analysis of nurse communication perceptions within the workplace used focus groups in examining elements of self-efficacy on the part of nursing personnel (Garon 2012). Three thematic categories emerged representing barriers to nurses' ability to speak up included influences, message transmission and outcomes. These categories were further broken down to the following: influences into personal and organisational, message transmission to passion and nonvocal, and outcomes to receiving feedback and empowerment.

The study found that nurses' perception of ability to openly communicate was mostly influenced by the nurse manager. Nurses require a feeling of being valued and heard by management as well as an environment of open communication. A primary recommendation emerging from the study was that nurse managers need to give attention to the communication culture in order to facilitate staff nurse development and performance.

Communication huddles

An investigation of the communication culture employed a measure referred to as the organization huddle process (Cooper & Meara 2002). That study demonstrated often in nursing, each unit or department is referred to as a team, such as the Emergency Department Team or Medical Surgical Intensive Care Team. The team includes everyone in that department from leadership to staff, but it also excludes everyone else. 'Teams often connote winning or losing. The intention is to win, and one cannot win unless others lose' (Cooper & Meara 2002, p. 13). This finding led to the development of organisational huddles from the concept of an ensemble. Based on the definition of ensemble, all groups or all invested are working towards the same goal. The study design included a designated time and place for the huddle to occur, but the focus was on process rather than structured agenda. It was a means of creating specified times to share information, resolve problems, collaborate with other participants and agree on deliverables (Cooper & Meara 2002). Given that the information was only communicated in the huddle, it was then up to those who attended to bring the information back to their respective departments. This resulted in those departments developing their own huddle process to bring the organisational huddle information to all of their staff.

Success of the new huddle process was measured through participant feedback. Participants expressed great



Information from many sources is diverted to the "Clinical Chatter" editorial team where information is filtered and presented to the patient care leadership and nursing staff with a standardized message.

Figure 1 Conceptual Model. Information from many sources is diverted to the 'Clinical Chatter' editorial team where information is filtered and presented to the patient care leadership and nursing staff with a standardised message.

satisfaction with expedient turnaround times on requests, information sharing and the building of positive business relationships. Additionally, the huddle became a familiar and acceptable means of conducting business within the organisation (Cooper & Meara 2002).

Nursing huddles have become the new 'fad' in nursing communication. Hyde wrote in the Critical Care Nurse journal about how her organisation implemented a 'Cardiac Huddle' for their 50-bed cardiac intensive care unit (Hyde 2008). It was a platform to communicate core measures and quality outcomes and hold staff accountable for the information and take ownership for solutions. According to Setaro and Connolly (2011), other huddles were created in a postanesthesia care unit (PACU) to increase patient

safety. Finally, Nationwide Children's Hospital conducts medication huddles after each reported adverse drug event (Nationwide Children's Hospital 2014).

Many different approaches had been created to combat the need for information and knowledge distribution, yet there was still no single standard. The term 'huddle' seems to be the term that was used to describe this communication, yet the format varies from organisation to organisation and department to department. Some allowed for all staff to participate while others request only representatives. Some included interdisciplinary members while others are strictly for nursing. While some were successful at creating a platform for communication, others struggled to maintain momentum and staff buy-in. It was clear that no

organisation, thus far, had developed an innovation or tool to ensure that all nurses have one standardised form by which they received communication from their organisation and their department to stay informed.

Communication training

Although at birth, we are born with the ability to communicate, either through speech or sign language, for example it is a skill that often times needs additional training to master. Communication is essential for nurses to do their jobs; thus, it should be essential they receive communication training along with their pharmacology and physical assessment curriculum. A study in Canada was performed to improve the practice environment on a critical care unit (van der Wal *et al.* 2008). Once the priorities of what issues needed to be addressed by the staff were determined, unit 'champions' were enlisted to help employ their colleagues and work on solving those identified issues. Next, four different interventions were developed to help the staff gain the communication skills necessary to be able to solve their unit issues. The first of the interventions included five blitz sessions in which 'solutions related to communications, collaboration, education, leadership support, workload, and workflow management were generated'. Second were two organised retreats, which were heavily centred on team building and conflict management. The third was aimed more at unit leaders to further their ability to engage their staff. Finally, training for all staff was held to specifically address communication and conflict as a group. Not only did each intervention address communication skills in some form, but also each approached it in a different educational platform, from blitz sessions to retreats and unit leadership to entire unit participation. Results of this study showed that these interventions of communication training led to higher scores on their survey of staff perception of 'adequate staff and resources, educational development and professional growth, collaborative relationships with team members and respectful relationships' (van der Wal *et al.* 2008). Thus, education around communication skills can improve the ability of a particular nurse or an entire unit, and this leads to a more positive work environment.

Innovation

There are approximately 850 nurses led by 55 managers and directors at Presence St. Joseph Medical Center in Joliet, Illinois. In spite of the size of the institution, a formal method for clinical communication did not exist. The communication structures were haphazard and left to

individual units to implement. There were many different methods of communication from administration to leadership, but they were not consistently used, such as monthly leadership meetings with all managers and directors of the organisation, email updates and unit-specific manager and director meetings. While nursing administration and leadership felt as if they had open lines of communication that ensured nursing staff were informed, anecdotal evidence indicated a gap between leadership and bedside nurses. Much like the game of telephone, if a change in practice was implemented, only a fraction of the bedside nurses seemed to be informed and to have changed their practices. It would create a lot of chatter on the units and, in the end, cause more disdain than change. The nurses on the unit would become angry that they were not informed and educated about the change and would also question its validity and often times not change their practice. This could cause a vicious cycle. So the leadership decided to flood the units with various forms of communication on information updates in hopes that eventually they would reach each nurse on the unit. Posters hung in staff bathrooms, flyers in the break rooms, monthly staff meetings and daily shift huddles along with emails were used as methods of communication. It eventually reached a point at which the leadership, the managers and directors, were not able to maintain the updating of numerous forms of communication with the constant change that comes with the nursing profession. A poster would miss being updated or one piece of information would be left out in the huddle, and they were right back at square one with an uninformed unit.

The Shared Governance Committee (SGC) determined that there needed to be only one form of communication used, which the 850 bedside nurses were responsible for checking in order to stay informed. It was voted upon and resolved that the form of communication would be an email. The reasoning was that every nurse in the organisation had an email address, and administration and leadership could be assured that information was delivered. It was then the nurse's responsibility to open and read the emails. All other methods of communication could then be used to reinforce the information in the email, but were no longer to be considered the main source.

Now that email was determined to be the main source of information for the bedside nurse, a tool needed to be developed. The SGC envisioned a tool that can ensure that each of the 850 nurses will be successfully informed on all changes and information organisation wide. When the SGC members approached the Hospital Administrators about the tool, the SGC learned that a weekly huddle

among all leadership staff was already being created to ensure open lines of communication. The SGC, on which the investigator served as chair, developed and refined this tool based on information that had been learned from the weekly leadership huddles. As seen in Appendix A, the tool has multiple sections that were created to ensure that new and important information were conveyed in an organised manner, to allow bedside nurses to quickly read through and retain vital information. This tool was also designed to not only keep the nurse informed of changes on their unit, but also provide information relative to the organisation, new resources and practices, acknowledgements of their fellow nurses, and circulating rumours that required clarification. The top four boxes of the tool: What's Happening Around the House; New Tools, Resources and Practice Changes; Words on the Street; and Recognizing Remarkable, were to be filled out by administration prior to their weekly huddles with leadership. The idea was that these topics were the information and news that were considered constant in the organisation and did not need any change before sharing to each hospital unit. After each huddle, the filled out template would be sent to each member of leadership, at which time they would fill in the last box pertaining to any changes and information specific to their unit. Each unit's leadership team would then send out the completed email to their nursing staff once a week. A universal subject header was created to ensure that every nurse in the hospital knew that if at the beginning of their shift they only had enough time to read just one email, it would be this one. It was titled 'Clinical Chatter' (Appendix A).

Methods

Research design

This study used a descriptive, cross-sectional study design.

Setting

The study was conducted at Presence St. Mary's Hospital in Kankakee, Illinois. This is a nonacademic acute care suburban hospital serving Kankakee and its surrounding counties. This facility serves 30,760 patients annually, of which 5493 are hospital admissions.

Sample and sample size

There are a total of 306 nurses serving at this hospital including both bedside nurses and patient care managers.

For the purpose of this study, convenience sampling of all 280 bedside staff nurses at Presence St. Mary's Hospital was used. Participants were recruited and informed about the study via anonymous online surveys (Appendices B and C).

Instruments

Clinical Chatter

This tool was developed by the Clinical Leadership Council (CLC), which is also the SGC, at Presence St. Joseph Medical Center. The SGC is considered as the clinical and professional decision-making body for the nursing leadership of the hospital. It is composed of unit-based leadership council chairs that represent every unit across the medical centre. The purpose of the SGC is to provide a forum that promotes bedside nursing participation in decision-making, promotes communication and collaboration among nurses and evaluates recommendations regarding clinical practice, quality/safety initiatives and the work environment. After 'Clinical Chatter' was presented and recommended revisions were made, the CLC reviewed and approved the tool to be used as a communication for its nursing staff, which established the face validity of the tool. To evaluate whether 'Clinical Chatter' was an acceptable and usable method of routine communication for nurses, each staff nurse was asked to complete the acceptability and usability questionnaires.

Acceptability Scale

The original scale was developed by University of Washington researchers in 2011 to evaluate patient-reported outcomes in cancer care (Tariman *et al.* 2011). Tariman *et al.* (2011) initially reported that the Acceptability *E*-scale is a valid and reliable tool with a Cronbach's alpha coefficient of 0.757 ($n = 627$). For this current study, the modified Acceptability Scale was found to be reliable with a Cronbach's alpha coefficient of 0.944 ($n = 123$). The six items in the Acceptability Scale were modified to make them appropriate for this study. For the six items, each 'offers five response options: A response of 1 indicates a negative and 5 indicates a positive evaluation' (Tariman *et al.* 2011). The study participants were asked about their opinions on the 'Clinical Chatter' in terms of ease of use, understandability of the contents, enjoyment of the tool, helpfulness of the information provided and acceptability of the amount of time it took to read the entire tool. The overall satisfaction with the Clinical Chatter as a communication tool was also queried. Permission was obtained from Joseph Tariman to use and adapt the Acceptability *E*-scale (Appendix D).

Usability Scale

The scale was developed by Otani *et al.* (2013) to evaluate the usefulness of an educational leaflet that was distributed to family members of delirium patients. Otani *et al.* (2013) reported that the Usability Scale's face validity was established after a small pilot test. 'Answers to questions were rated on a four-point Likert-type scale ranging from 1 (not at all useful) to 4 (very useful)' (Otani *et al.* 2013). The Usability Scale for the present 'Clinical Chatter' study had a good reliability with a Cronbach's alpha coefficient of 0.965 ($n = 123$). Permission was obtained from the primary author to use and adapt the usability questionnaire (Appendix E).

Implementation procedure

For the purpose of this study, 'Clinical Chatter' was implemented at a regional sister hospital, Presence St. Mary's Hospital (PSMH) in Kankakee, Illinois. The staff had the same issue of an inundation of information from many different sources without a standardised message or delivery system. There were approximately 280 staff nurses led by 10 managers and directors. The shared governance of PSMH, Patient Care Council, reviewed the 'Clinical Chatter' tool and recommended implementation. The goal was to replicate the same positive feedback that the staff at Presence St. Joseph Medical Center (PSJMC) had, with an ultimate goal of one day being able to integrate some of the information across both sites and create a best practice of having standardised information delivered across a hospital network at a regional level.

Preimplementation of 'Clinical Chatter'

Prior to implementation, approval was received from PSMH institutional review board. 'Clinical Chatter' was then revealed to nursing leadership during their weekly leadership huddle. The tool was explained in detail along with the expectation that patient care managers were to complete the unit-specific section and have it sent out to their staff by Tuesday at noon each week. The initial feedback from the patient care managers was positive, and they each agreed to participate.

A 'Clinical Chatter' editorial committee was formed. It was comprised of one of each of the following staff: a professional nursing practice and development team member, a patient care manager, a staff nurse, a nursing administrator and an administration secretary. This committee would meet each Wednesday to review the information to be placed into 'Clinical Chatter' for the following week and

complete the document. It was then presented on Monday morning during the leadership huddle for review. At this time, any questions or clarifications that needed to be addressed were done so with the opportunity to revise any aspect of 'Clinical Chatter' before it was sent out to the staff. Monday afternoon the finalised document was then sent out to each patient care manager. As discussed previously, each patient care manager was then responsible for completing the unit section with any information or changes specific to their unit. The expectation was that 'Clinical Chatter' was then sent out to their nursing staff by noon every Tuesday.

Implementation of 'Clinical Chatter'

The 'Clinical Chatter' communication tool for nursing staff was distributed weekly via email by noon every Tuesday. The staff had a chance to review the document via email at their convenience. It was implemented for a period of two months. No other communication regarding information or changes was delivered by any other method during this time. At the end of two months, nursing staff had received eight 'Clinical Chatter' documents to review. Their feedback on the tool was then evaluated.

Postimplementation of 'Clinical Chatter'

To evaluate whether 'Clinical Chatter' was an acceptable and usable method of routine communication for nurses, each staff nurse was asked to complete the acceptability and usability questionnaire. The questionnaire was hosted through Zip Survey, an online hosting service. The survey was to remain open for three weeks. On average, response rates for e-mail surveys can have a wide range of responsiveness. Based on a study by Cook *et al.* (2000), an average of 40% response rate was found when 39 separate online surveys were analysed (Pan 2010). Therefore, for this study, the targeted response rate was 40%.

Data analysis

Sociodemographic data were determined by a demographic survey (Appendix F) given with each acceptability and usability questionnaire. The demographic data surveyed included gender, age, ethnic origin and clinical nursing experience. The data were analysed with descriptive statistics and generated the frequency, mean, standard deviation and percentages of those responses.

Data obtained from the acceptability and usability questionnaires were reported with described data distribution, and the 95% confidence intervals were calculated.

Human protection

The project obtained Institutional Review Board approval from DePaul University. The protection of human subjects was upheld by ensuring that participants knew participation was voluntary, and all participants' responses were kept anonymous by not collecting any directly identifiable information or IP addresses. Participants were provided an information sheet that contained information about the purpose of the study, information about privacy, right to cessation of participation without penalty and contact information of researchers before participating in the study. All data were kept in a password-protected computer, and only three PIs and a research assistant had access to the data.

Results

Of the 280 bedside staff nurses at Presence St. Mary's Hospital, 146 chose to take the survey. Twenty-three of those survey results were discarded due to more than 50% missing responses in all 20 questions of the entire survey. Therefore, 123 completed survey results were used for analysis with an overall survey response rate of 44%.

Demographics

The demographic details were obtained using frequencies and percentages as shown in Table 1. There were 111 female respondents (90.2%), and only 12 were male (9.8%). There was a wide range in ages of the participants:

Table 1 Sociodemographic characteristics of study participants

Variable	Frequency	Percentage of respondents
Gender		
Male	12	9.8
Female	111	100
Age in Years		
60 and above	15	12.2
50–59	38	43.1
40–49	23	61.8
30–39	25	82.1
20–29	22	100.0
Ethnicity		
Native American	1	0.8
Black	1	1.6
Hispanic	2	3.3
White	119	100
Work Experience in Years		
6 or more	88	71.5
5–6	9	78.9
3–4	15	91.1
1–2	11	100

70 participants were 49 years old or younger (56.9%), and 53 participants were older than 50 years old (43.1%). The population was homogenous with 96.7% being of White ethnicity. Finally, more than 71% of those who responded had more than six years of nursing experience.

Sociodemographic variables and acceptability of Clinical Chatter

Age

The ages of the respondents who completed the survey were divided into dichotomous groups: those who were between the ages of 20–49 and those who were aged 50 or older (Table 2). The mean score of the Acceptability Scale for 'Clinical Chatter' for those in the two different age groups was analysed using the independent sample *t*-test method. Based on the calculated level of significance ($p = 0.979$, two-tailed test), age is not a factor in the acceptability of the Clinical Chatter. In other words, there was no statistically significant difference in the mean scores of the acceptability of the 'Clinical Chatter' between the subjects aged 20–49 and those older than 50.

Experience

The years of experience of respondents was divided into two groups: those with <6 years of experience and those with experience of six years or more (Table 3). Based on the calculated level of significance ($p = 0.710$, two-tailed test), there was no statistical significance between the mean scores for acceptability of the 'Clinical Chatter' between those with <6 years of experience and six years of experience and above.

Sociodemographic variables and usability of Clinical Chatter

Age

The age of the respondents who completed the survey was divided into approximately two equal groups: those who

Table 2 Dichotomous grouping based on age

Group	Frequency	Percent
20–49 years	70	56.9
50 years and above	53	43.1
Total	123	100.0

Table 3 Dichotomous grouping based on experience

Years of experience	Number of respondents	Per cent of sample
Less than 6	35	28.5
6 or more	88	71.5
Total	123	100

were between the ages of 20–49 and those who were aged 50 and older (Table 2). The mean scores of Usability Scale of 'Clinical Chatter' for those in the two different age groups were then analysed using the independent sample *t*-test method. Based on the calculated *p*-value (two-tailed test) = 0.442, there was no statistically significant difference in the mean scores on usability of the 'Clinical Chatter' between the subjects aged 20–49 and those who are aged 50 or older.

Experience

The years of experience of the respondents was divided into two groups: those with six years of experience or less and those with more than six years of experience (Table 3). The usability mean scores between the two groups of experience were analysed using the independent sample *t*-test. Based on the calculated level of significance for a two-tailed test (*p* = 0.69), there was no statistically significant difference of mean scores of the usability of the 'Clinical Chatter' between those with six years or less experience and those with more than six years of experience.

Discussion

Age

Technology has changed and advanced over the last few decades. Computers have change from large, heavy, microwave-sized machines of which each household had one, to a small, lightweight, notebook-sized necessities that many carry daily on their person. 'Information and Communication Technology (ICT) became an ever-important factor in recent years' (Nagle & Schmidt 2012, p. 3541). As these technologies have been developed, many studies have now been conducted to explore factors that contribute to computer literacy and usage. Age is one of these factors. Many older adults did not use much technology or computers in their everyday working life and started as novices much later in life. They did not have the benefit of learning and using the technology as it was developed to gain expertise. Nagle and Schmidt (2012) noted in their study, Computer Acceptance of Older Adults, 'a significant negative correlation was found between age and number of applications used on the computer' (p. 3545). Yet, as demonstrated by the survey results, the nursing staff at PSMH found the electronic communication tool 'Clinical Chatter' to be both an acceptable and usable form of communication regardless of their age. The frequency data show that more than 43% of those who participated in the survey were over the age of 50. Their positive feedback for the tool could be

attributed to their past knowledge of email, use of computers in their everyday work life, or that this communication tool helps to condense and organise the electronic information that they are receiving. The reality is that it is likely a combination of all three factors.

Experience

In contemporary healthcare settings, change is a constant and the ones that feel that change the most are the nursing staff. Change in policies, procedure, protocols, medications and the list goes on. 'Nurses must constantly adapt to a variety of radical and incremental changes in the way they work, but their emotional responses can inhibit changes from being sustained in the practice' (Bowers 2011, p. 19). Thus, the more experienced nurses are often more resistant to change because they have seen so much of it over the years. More experienced nurses will often tell you the current process in question does not need to be changed because that is the way it has been done for years and has worked just fine. Yet, with more than 71% of those who participated in the study having more than six years of nursing experience, there was an overwhelmingly positive response to 'Clinical Chatter'. Not only did the experienced nurses respond that the electronic tool was an acceptable and usable form of communication, but also did the less experienced and novice nurses. It is evident by the results that regardless of the number of years of nursing experience the nursing staff found 'Clinical Chatter' to be an acceptable and usable form of routine communication.

Limitations

No re-test reliability was used due to the nature of the instruments as a communications measure rather than a concept-based research instrument and study site restrictions. Also, results of the usability and acceptability of 'Clinical Chatter' based on ethnicity or gender could not be analysed due to a homogenous sample that chose to participate.

Future research

Communication is vital to advancing health care. Lack of communication among nursing is not unique to only one ministry. Next, I would like to see the 'Clinical Chatter' communication tool implemented across a healthcare system and a mixed method research study conducted to demonstrate the effectiveness of the tool among a greater number of clinical nurses. I believe if used correctly this

tool can help to increase the speed at which systems are able to standardise their practice across multiple ministries, thus ensuring best practices are being used across a system to increase nursing awareness and compliance, consequently improving patient outcomes.

Conclusion

There was not one consistent information delivery method currently in place to ensure that bedside nurses have the most up-to-date information necessary to provide excellent patient care critical to the performance of their job. This study evaluated a new communication tool and assessed the

acceptability and usability of a newly developed 'Clinical Chatter', a standardised communication tool that facilitates routine dialog and ensures nurses are consistently informed of the most concise and up-to-date information to perform their job. It was evident by the results that regardless of demographic factors, the nursing staff at PSMH found 'Clinical Chatter' to be an acceptable and usable form of communication to ensure every nurse is informed.

Contributions

Study design: CT, MS; data collection and analysis: CT; manuscript preparation: CT, JT, MS, LW.

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Appendix A



Clinical Chatter
Week of...

WHAT'S HAPPENING AROUND THE HOUSE
WORD ON THE STREET
WHAT'S HAPPENING IN OUR UNIT

NEW TOOLS, RESOURCES & PRACTICE CHANGES
RECOGNIZING REMARKABLE!

Appendix B

Recruitment Email

In an effort to improve communication within Presence Saint Mary Hospital, please take a few moments participate voluntarily in the following surveys to determine the acceptability and usability of 'Clinical Chatter' as a communication tool. Your feedback will help shape the communication plan and ensure every nurse is informed. Please give your honest answers. All of your responses are anonymous and cannot be traced to you. . .only overall data will be presented.

Thank you in advance for your participation,
Carolyn Talbott, RN

Appendix C

Information Sheet for Participation in Research Study

'Clinical Chatter' Every Nurse Informed

Principal Investigator: Carolyn Talbott, RN, MSN, DePaul
University Graduate Student

Institution: DePaul University, USA

Faculty Advisor: Dr. Matthew Sorenson, PhD, APN, ANP-C, Associate Director DePaul School of Nursing

We are conducting a research study because we are trying to learn more about the communication tool ‘Clinical Chatter’. We are asking you to be in the research because you are a bedside staff nurse at Presence Saint Mary Hospital Kankakee, IL. If you agree to be in this study, you will be asked to complete the following surveys. The surveys will include questions about the acceptability and usability of ‘Clinical Chatter’ as a communication tool. ‘We will also collect some personal information about you such as age and years of nursing experience’. This research study will be completed online via Presence Health email.

This study will take about ten minutes of your time. Research data collected from you will be anonymous.

Your participation is voluntary, which means you can choose not to participate. There will be no negative

consequences if you decide not to participate or change your mind later after you begin not the study. You can withdraw your participation at any time prior to submitting your survey. If you change your mind later while answering the survey, you may simply exit the survey. Once you submit your responses, we will be unable to remove your data later from the study because all data is anonymous and we will not know which data belongs to you. Your decision whether or not to be in the research will not affect your employment at Presence Saint Mary Hospital.

If you have questions, concerns, or complaints about this study or you want to get additional information or provide input about this research, please contact Carolyn Talbott at 630-362-0416.

If you have questions about your rights as a research subject you may contact Susan Loess-Perez, DePaul University's Director of Research Compliance, in the Office of Research Services at 312-362-7593 or by email at sloesspe@depaul.edu. You may also contact DePaul's Office of Research Services if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.

You may keep [or print] this information for your records.

Appendix D

Acceptability Scale

5) How easy was the 'Clinical Chatter' to review?

1	2	3	4	5
Very difficult				Very easy

6) How understandable was the 'Clinical Chatter'?

1 2 3 4 5

Difficult to Understand Easy to understand

7) How much did you enjoy participating in this ‘Clinical Chatter’?

1	2	3	4	5
Not at all				Very much

- [illegible]

Appendix E

Usability scale

- | | | | |
|---|---|---|-------|
| 1) The Clinical Chatter helped me understand what new tools and resources are. | | | |
| 1 | 2 | 3 | 4 |
| Disagree | | | Agree |
| 2) The Clinical Chatter helped me identify what I could do to advance my professional development. | | | |
| 1 | 2 | 3 | 4 |
| Disagree | | | Agree |
| 3) The Clinical Chatter helped me understand how misinformation could contribute to poor patient outcomes. | | | |
| 1 | 2 | 3 | 4 |
| Disagree | | | Agree |
| 4) The Clinical Chatter helped me understand how to improve my overall nursing process | | | |
| 1 | 2 | 3 | 4 |
| Disagree | | | Agree |
| 5) The Clinical Chatter was useful in preparing me for my shift. | | | |
| 1 | 2 | 3 | 4 |
| Disagree | | | Agree |
| 6) The Clinical Chatter was useful in indicating what I could do in my practice to make improvements to patient care. | | | |
| 1 | 2 | 3 | 4 |
| Disagree | | | Agree |
| 7) The Clinical Chatter was useful in explaining strategies to help avoid making poor clinical decisions. | | | |
| 1 | 2 | 3 | 4 |
| Disagree | | | Agree |

- 8) The Clinical Chatter was useful in indicating what I needed to do to make good decisions regarding care of patients on my specific unit.
- 1 2 3 4
Disagree Agree
- 9) The Clinical Chatter explained information that I wanted to know.
- 1 2 3 4
Disagree Agree
- 10) The Clinical Chatter was useful in making me feel more comfortable with making good professional advancement decisions.
- 1 2 3 4
Disagree Agree

Appendix F

Demographics/Acceptability Survey:

Please complete the following survey based on your participation in ‘Clinical Chatter’. The information from this survey will be used to evaluate the ‘Clinical Chatter’ communication tool. Your participation is anonymous and voluntary.

Demographic Information

- 1) What is your gender?
Male
Female
- 2) What is your age group?
20–29
30–39
40–49
50–59
60 and above
- 3) What is your ethnic origin?
White
Hispanic/Latino
Black/African American
Native American/American Indian
Asian/Pacific Islander
Mixed Race
- 4) How many years of clinical nursing experience did you have?
<1 year
1–2 years
3–4 years
5–6 years
>6 years