HOME HEALTHCARE FACILITIES: A QUALITATIVE STUDY OF COMMUNICATION METHODS IN HOME HEALTHCARE FACILITIES

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Doctor of Management

By

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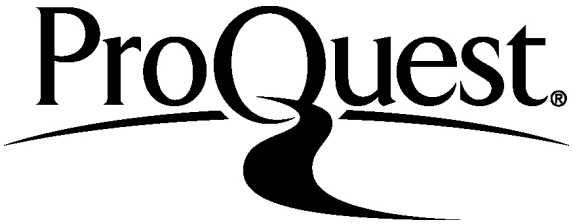

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Abstract

The purpose of this qualitative phenomenological research study was to understand communication between home healthcare managers and healthcare providers in small facilities. The research problem addressed a lack of communication between managers and subordinates, leading to ineffective decision-making in home healthcare. The research question was: what are the lived experiences of home healthcare professionals regarding communication between managers and subordinates to facilitate patient care turnover? The study was guided by a conceptual framework consisting of Communication Accommodation Theory, Human Relations Theory and the Systems Relations Theory. The research method consisted of one-on-one semi-structured interviews, containing ten open-ended questions to 16 participants in two home healthcare facilities. Results were coded to identify prominent themes. Five major themes were derived from the research. First, participants perceived that direct verbal/telephone communication was successful. Second, participants perceived that in-service training was the key to communication.. Third, proper care could be communicated by using methods like a pillbox. Lastly, successful communication often occured when management issued an efficient plan of care**.** The study evaluated home healthcare communication by looking at what works and what does not. The study found that phone calls work better than emails and text messages. There remains room for improvements, such as looking at methods like Quality Assurance Performance (QAPI) or Situation Background Assessment (SBAR)).

Keywords: Patient Care, Qualitative Study, Home Healthcare, Phenomenology, Quality Assurance Performance Improvement, and Situation Background Assessment Recommendation

Dedication

I dedicate this accomplishment to my mother, Barbara Burgess. My mother encouraged me to be the best that I could be, and never quit. Just as important in my life are my wife and children. I send a special thank you to my wife, Treva, for her patience and support during the development of this dissertation. I am thankful for my children, Kamera, Khalil, Bakari, and Amare, who supported my academic journey. My wife and children have provided me with the stability and focus to achieve this degree over the last three years. Finally, I send special thanks to my mentor, Dr. Schmitt, for her relevant guidance on research and writing.

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The completion of this program—primarily, the writing of this dissertation—was the most challenging academic event of my life. It was also the most rewarding event. First and foremost, I acknowledge my Lord and Savior, Jesus Christ, who leads me through all things, and provided the will to complete my doctorate. It is through You that I live, move, think and am here. You provided favor upon me to complete this degree and provide favor for me to use it as You will. Second, I want to acknowledge my family, friends, cohort members, and CTU staff, who supported me on this journey. As the stress became increasingly evident, you provided me with assurance that I could and would prevail.

To the two labelers, thank you for giving me an additional set of eyes in transcribing and then coding all of the interviews with me. Your insights were truly invaluable in helping me think about the data in unique ways.

Next and just as important, I would like to offer my unending thanks to Professor Alexa Schmitt, who was very patient with me throughout the entire process, ensuring that I had everything I needed to succeed. Professor Schmitt challenged me to think and write academically by teaching me what it takes to be a Doctor of Management. Without the guidance of Dr. Schmitt, this journey would have had no limit, and this dissertation would be unwritten. I applaud Dr. Schmitt for her part in molding me into an academic and now a doctor of this program.

To my research participants, thank you for taking the time out of your busy schedules to speak with me about your experiences and answer my questions. Moreover, I would like

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CHAPTER ONE

The purpose of this phenomenological study was to understand interdisciplinary communication between home healthcare managers and healthcare providers in a small facility. Small home healthcare facilities are defined as agencies that care for a smaller patient to employer ratio of senior citizens. The difference between a smaller and large facilities is residential location. Smaller home healthcare facilities are normally located in residential neighborhoods, with lower staff to patient ratio, due to a smaller number of seniors. The central communication phenomenon is defined as moving information from one process or individual to another process or individual within home healthcare.

The research explored forms of communication currently being used in home healthcare agencies. The research problem proposed in this study addressed a lack of communication between managers and subordinates, which leads to ineffective decision making. This research looked to explore communication processes between home healthcare managers and their staff. Contribution to the body of knowledge was established by furthering research through observation of the relationship between managers and subordinates as seen in day-to-day decision making. There remains a need for home healthcare facilities to catch up with major healthcare industries in many processes in order to enhance communication measures (DeVore, 2014). For instance, a breakdown in communication is evident when errors are committed through lack of understanding procedures (Ellenbecker, et al. 2007). Home healthcare is unique in regards to the application of federal regulations in the field, relating to faster growth, and saving on medical spending (Miller, et al. 2003). Professionals who work in this area often spend less time with direct supervision due to geographical disbursement; creating a

lack communicative direction (Ellenbecker, et al. 2007). Thus, the importance of establishing improved communication and coordination is evident.

This document described a research study that examined the nature of communication methods managers use to ensure home healthcare effective decision making. The research was organized into five chapters, which are explained below. The first chapter covers the research problem by exploring and reflecting on home healthcare communication through suggested methods. This chapter also covers the significance of the research, delimitations, limitations, and definitions of the terms provided. Chapter one provides a general overview of the research design and the organization of dissertation.

Background

An estimated eight million people required medical care in 2014; thus, effective communication is a huge factor in the healthcare industry. Moreover, lack of communication in medical facilities, both internally and externally, is a challenge for home healthcare as well as in-patient and out-patient connectivity. Having the ability to communicate relates directly to factors that are used in effective decision making. Thus, effectiveness can be a by-product of communication and coordination. Research conducted by Dartmouth University (2007) concluded proper decision making reflects the ability to maintain and provide adequate healthcare. The Dartmouth study focused on communication in home healthcare facilities. The study was confined to face-to-face and phone interviews.

Although much research has been conducted on communication gaps between healthcare providers and patients, very little research has addressed the communication

gap between employees in home healthcare and healthcare in general. This study was exploratory and contributed to the concept of communication in home healthcare by addressing communication practices in this regard. For the purpose of this study, communication is described as: exchanging information from one process or individual to another process or individual with in-home healthcare.

Anderson & Helms (2007) suggested that communication is the core task of coordinating patient care. For home healthcare, it is critical to explore communication, as it directly affects economic sustainability, efficiency, and patient care in the industry. With the population aging, the home healthcare industry has become a significant part of the healthcare community. A study from the Centers for Disease Control and Prevention (CDC) (2015) shows home healthcare as the primary choice of retiring personnel who wish to remain in their homes. This research looked at the vitality of home healthcare—the implementation of communication strategies in home healthcare organizations—which includes using multiple behavioral and social learning theories. Moreover, the study provided input from home healthcare personnel about communication practices, including identifying attitudes and behavior. Meaningful study results may be valuable to home healthcare practitioners and home healthcare staff (Glatthorn, Rouse, & Joyner, 2013). The research was structured in terms of philosophy and cross-sectional perspective using interviews and data. An innovative feature of the program is that the income from non-borrowers can be counted as part of the debt-to-income ratio, which compares all monthly minimum payments to your monthly gross income.

While other loans only allow borrowers' incomes to be considered, this program recognizes that many households include extended family who contribute to the housing

payment even when they are not the homeowners. In some cases, borrowers can include income from non-occupant borrowers, such as their parents.

Other fees will be lower on these loans. For example, borrowers who have a credit score of 680 or higher won't pay any extra fees or a higher interest rate, unlike typical loans that require a bigger payment for borrowers with a credit score below 740.

All borrowers will be required to take a home-buyer education course. The loans are limited by income in some areas but waived in low-income areas.

Specifically, this study focused on the problem of internal communication between managers and subordinates that led to ineffective decision making. Communication is a skill that many people need to know (Taylor, 2015). In the healthcare field, communication is a valuable skill because it enhances quality of care by establishing links between medical professionals and patients (Taylor, 2015). Woolf et al. (2004) opined that organizations can avoid substantial errors by dealing with communication problems effectively.

Relevant Theories

Human Relations Approach Theory is a relevant theory that frames the approach to how management can better use communication to make productive decisions. Between the late 1930s and the present, theorists such as Giles (1991), who developed Accommodation Theory, Christians (1997), who innovated Communication Ethics, and Janis (1972), founder of Groupthink, provided research regarding the needs of employees. These needs included social interaction and individual achievement (Benger, 1990). This study derived from Human Relations Theory and builds upon it in the healthcare management concentration using theorists such as Herzberg (1959). The

Human Relations Theory illustrates communication between people about social topics and work. The human relation approach was developed by professor, Elton Mayo to communicate with employees in a socio-psychological nature. In Human Relations Theory, employees' satisfaction about active participation in work is monitored (Wrench, 2007).

There is an opportunity in the field of healthcare management to understand the nature of this disconnect between communication and sound decision making and establish a more efficient work environment. This research is needed to provide accurate treatment and safety in home healthcare facilities. The healthcare management field calls for sustained medical operations that allow for proper diagnosis and decrease legal ramifications about healthcare management. This perspective effectively relates the communicative problems being sustained in these facilities (Hardy & Jaynes, 2011).

This study allowed for qualitative analysis, showing the viewpoints of both management and employees. This study was based on gaps in current and recent studies in healthcare communication. Additionally, the study was based on interviewing appropriate individuals to build concepts to establish effective communications.

Problem Statement

The research problem proposed in this study addressed a lack of communication between managers and subordinates, which leads to ineffective decision making in home healthcare. Proper decision-making is important because communication is the exchange of information that symbolizes the change of meaning (Taylor, 2015). Through this symbolic meaning, individuals are implanted in such roles as caregiver, administrator, and physician. According to the Agency for Healthcare and Quality (2015), these

functions are important in healthcare settings, providing for a decrease in patient harm, length of stay, and resource usage, as well as caregiver satisfaction and less employee turnover, . The breakdown in communication in home healthcare had often been due to misinterpretation of facts, lack of communication, time, and limitation upon the exchange of information. Moreover, the breakdowns occurred because feedback was not provided to allow for clarification and proper interpretation. Studies have shown that these factors have led to several complications (Sutton, et al. 2012). The home healthcare industry experiences the same breakdowns, including misinterpretation of instructions, resulting in medical errors. The research was structured regarding philosophy, inductive approach, and cross-sectional perspective, using interviews for data collection. This study examined industry experiences, suggesting methods such as Quality Assurance Performance (QAPI) or Situation Background Assessment (SBAR), which have been widely accepted but rarely used in home healthcare (NAHC, 2015). QAPI is a process that measures quality by communicating the situation and background of the issue. SBAR can be used to assess the situation and background of the issue, providing a recommendation.

Purpose Statement

The purpose of this qualitative research was to understand interdisciplinary communication between home healthcare managers and healthcare providers in a small facility. Thus, the intent of the study was to look at communication practices within the home healthcare industry. The central phenomenon of the study is a lack of communication. The participants in the study were home healthcare managers, clinicians, and administrative staff in the organization. This study added to the process of

narrowing the gap between managers and employees with the provision of communication methods that produce quality, efficiency, and safety in home healthcare.

Research Question

To find out how communication methods relate to management efficiency and overall healthcare capability in home healthcarefacilities, the overarching research question was: What are the lived experiences of home healthcare professionals regarding communication between managers and subordinates to facilitate patient care turnover? Patient care turnover happens when patients move to another agency for several reasons, to include miscommunication among the patient, staff, and providers.

Propositions

The current study proposed that communication methods can be used to help promote better communicative practices in home healthcare facilities. Earlier research results suggested that managers can emphasize communication through methods such as Quality Assurance Performance Improvement (QAPI) and Situational Background Assessment Recommendation (SBAR). In this study, an interview protocol was employed with a pre-determined set of questions based upon these propositions to ask every participant primary and secondary questions based on communication practices.

Conceptual Framework

The conceptual framework for this study is derived from Communication Accommodation Theory, Human Relations Theory, and the Systems Relations Theory (Huse & Bowditch, 1973; and Bertalantffy, 1940). To create a system of communication, the conceptual framework was constructed through an extensive review of the literature. This study compared well with previous studies developed by theorists Tamas (2010) and

Varkey (2012), which invites system and human relations theory as constructive. According to Glatthorm and Joyner (2005), conceptual framework was identified by painting a picture, which pinpoints the major concepts involved in the phenomenon.

The study confirms that the System and Human Relations Theory, Communication Accommodation Theory, and Systems Theory are all vital in communication practices (Shaked & Schechter, 2013 and Conrad, et al. 2015). These concepts can assist with a lack of communication between management and staff in health and home healthcare facilities. Adequate systems and human relations ultimately create proper decision making for appropriate healthcare (Tamas, 2000).

Communication Accommodation Theory helped provide clarity about why people change conversational tone when dealing with others. For example, Giles (1973) observed that people tend to change conversational tone and conduct as they are establishing rapport. The theory behind this is convergent and divergence. Convergence relates to how individuals imitate and copy others. Additionally, it includes copying mannerisms, leading to the hope of improved communication. Divergence is the opposite, which emphasizes the differences between the individuals that impact communication and relationships. Healthcare workers use these proponents to converge with fellow employees and diverge from the impact of the employee relationship (Giles, 2011).

Systems Theory is also vital to the study because it allows interaction between two systems, such as employee and employer or employer and patient (Tamas, 2010). Therefore, interaction is critical for the focus of healthcare. Bertalanfy (1928) opined

that Systems Theory can provide adaptive systems, goal attainment, integration, and maintenance of paradigm shifts.

Human Relations Theory is relevant in organizations that seek to motivate through relationships and positive communication practices. For instance, enhancement of the communication process brings value to an individual's esteem factor and allows productivity in an employee's team or group setting (Tamas, 2010). These theoretical perspectives were pulled together to create a conceptual framework that outlines the necessity of engaging communicative methods in home healthcare.

Assumptions/Biases

According to Leedy & Ormrod (2005), if the research is to be trusted, biases and assumptions must be addressed. Standing outside, the box provides a better view of both sides of the equation, in regards to subordinate communication and enhancing the medical safety of those affected. Assumptions were made that an individual level of knowledge was produced, and participants would obtain the nature of the study. Second, communication skills are crucial components of proper management preparation, leading to adequate communication practices. Lastly, the use of SBAR in the current work organization as an informative communication method is a bias. Because of the success of SBAR in many organizations, including hospitals and clinics, biases can be associated with possible perceived benefits to home healthcare facilities.

Significance of the Study

The intent of this study was to contribute to the overall knowledge base about communication practices in the home healthcare industry. This study specifically focuses on the use of current communicative methods that encourage communication between

managers and subordinates, creating effective decision making. It also sought to establish improved communication and coordination process in .home healthcare. The Institute for Healthcare Communication (IHC) conducted an important study on communication in 2013. The IHC study found that there is further opportunity to improve upon the manager and subordinate communication process. Ineffectiveness has led to increased malpractice risks, non-adherence, patient and clinician dissatisfaction, and poor patient health outcomes. Thus, addressing management communication skills is a necessity for organizations.

This lack of communication management has created disastrous results in current medical practices. The proposed research study explored the characteristics of mismanagement by managers by targeting the communication process between managers and subordinates in home healthcare. Smaller facilities served as an appropriate starting point for determining the complexities and nuances in improving communication and responsive environments that ensured all managers and subordinates are on the same page. Studies from the IHC indicate the existence of an opportunity to add to the lack of communication between medical staff and correctional staff and remove the negative outcomes (IHC, 2013).

Delimitations

This study was confined to the Arlington, Mansfield area of Texas. This selection was a relevant sample of the area, based on the representation of the Dallas/Fort Worth metropolis, with various medical facilities located in both Arlington and Mansfield. The study was bound by these delimitations.

Limitations

In some aspects, the research was limited in nature. First, previous and current profession was a source of some of the limitations and biases in this study. For example, in this study specifically, military experience provided a particular outlook on proper communication. Limitations were also associated with lack of experience in the medical industry. Additional limitations of this study were subject to the participation of various facilities. For instance, some facilities limited participation due to potential privacy and competitive concerns. Limitations were also seen in interviews, regarding credibility of participants. Because of this, the study was limited to the honesty of the subjects' responses during the interviews. Moreover, there was no validated survey tool available with which to conduct this research. Therefore, a new tool was developed for the study.

Definition of Terms

The following definitions were used during this dissertation research study:

Communication Accommodation Theory, which was developed by Howard Giles in 1971, states that people tend to change their styles of speech when talking with people, modifying those styles to match the speaker's perceptions of the listener. This theory was relevant because communication is a process of talking to and listening to people, thus providing a social exchange. People tend to speak like their listeners and modify their diction rates and tones accordingly. Accordingly, the speakers tend to imitate behavior habits of those with whom they are interacting (Giles, 1973). This trend is significant because it looks at the reason individuals emphasize or minimize the social differences between themselves.

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996. This regulation is designed to improve healthcare issues such as access to healthcare, availability of health insurance, and simplification of administration and delivery of healthcare services (Beaver, 2003). Organizations are required to be HIPAA compliant, which means protecting the organization and clients. This compliance is important, because healthcare, in general, is charged with safeguarding administrative, physical, and technical concepts patient health.

Malpractice refers to improper, illegal, or negligent professional activity or treatment, especially by a medical practitioner, lawyer, or public official (Varkey, 2010). Understanding what should be provided to patients and employees alleviates the chances of health and professional malpractice.

Patient-centered care, according to the IOM (2014), provides care that is responsive and respectful of individuals. It is representative of patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions (IOM, 2014). Effective communication between individual patients and their personal physicians is vital to the effective delivery of proper care. The exchange of information can be facilitated through patient-centered care, thus establishing open communication between patients and medical professionals.

Patient Protection and Affordable Care Act was established on March 23, 2012. This act empowers patients with the right to receive health information, choose their medical providers, gain access to care, file grievances, and appeal denied health benefits claim, all in an affordable manner (Parks, 2011). This act is a major tool that healthcare organizations use to provide stability and flexibility of coverage, cost, and care.

Quality Assurance and Performance Improvement (QAPI) is the process of meeting quality standards and assuring that care reaches an acceptable level. QAPI is provided through continuous analysis of performance and developing systematic efforts to improve it (ACHA, 2015). QAPI can provide the ability to process quality standards through continuous analysis of performance improvement.

Situation Background Assessment Recommendation (SBAR) is used to create an environment in which a team can work together more efficiently. It also increases overall operational excellence regarding the safety of the patients they serve (Cunningham, et al. 2012). SBAR has shown to be critical in helping hospital organizations bridge gaps in communication. In home healthcare, this recommendation helps medical professionals gain a better understanding of their patients' situations, backgrounds, assessments, and recommendations. This enhanced interaction creates shared expectations not only between patient and staff but also between staff members.

General Overview of the Research Design

The chosen research design was qualitative using exploratory analysis to establish and indicate the issues of communication. The research also emphasized a phenomenological view in which reality inheres in the perceptions of communication through individuals (Glatthorn & Joyner, 2005). Quantitative methods were not chosen because this study does not require the utilization of numerical representation. It is nascent in nature. A phenomenological approach provided understanding of the lived experience of personnel in the home healthcare industry. Phenomenology promoted the relationship between states of individual consciousness and social life. According to Orleans (2013), phenomenology enhances the sociological aspects of communication.

The phenomenological view was created by German philosophers Hussel & Heidesser (year?) who believe the research must provide the perceived reality of the issue (Orleans, 2013).

Focused groups or structured interviews were not used, allowing for more flexibility in the interview. Semi-structured interviews were appropriate for use because they created an opportunity for freedom of expression. Semi-structured interviews established rapport and trust. This positive interaction led to flexibility, which was required in producing reliable qualitative data. In summary, the chosen methodological design for this study was appropriate because they allowed the collection of in-depth information, thus adding greater responsiveness and clarity to the interviewing process. Moreover, existing theories such as Human Relations and System Theory were used to provide further clarity.

Summary of Chapter One

Chapter one provided the heart of this research, in terms of the problem of the study: it explored communicative methods and established processes between managers and subordinates in home healthcare. Moreover, this chapter indicated why the qualitative methodological design was the most appropriate system for the proposed study (CTU online, 2014).

Organization of Dissertation

The dissertation is organized into five chapters. As discussed, Chapter One covered the background of the research, indicating the problem and purpose of the research. Additionally, it provided the system that is used for the study. Chapter two contains the review of literature, which explores the research involved in the study

design. This chapter addresses the research by providing analysis of context, seminal literature, and recent literature, using peer-reviewed sources through subject matter experts. This chapter identifies and substantiates a gap in the body of knowledge that was addressed through this study. Chapter two also introduces the conceptual framework, where the research is built upon previous work and theory, using this foundation to paint a picture to relate components.

Chapter three contains a detailed discussion of the method used, and describes and justifies the research design. The design of the study was driven by induction and exploration as well as the researcher's role and data sources. Included in this chapter are research questions, participants and selection, instrumentation, data collection, and analysis, as well as considerations for the ethical protection of members (Joyner, et al. 2013). Additionally, the process of coding and categorizing data is explained in chapter three. The plan had been to use qualitative phenomenological research as the methodology, which is exploratory.

Chapter four covers the presentation of the findings of the data collected through interviewing methods, followed by a narrative. Insights into the representation and selection of data are interspersed with the discussion of the data.

Chapter five introduces each theme that emerged from the study and provides appropriate quotations from participants that are representative of the theme. This chapter delivers highlights of the data analysis process appearing in the findings, and these highlights emerge in the course of narrative where the results are explained. Chapter five presents a brief discussion of the population under study and the methodology used for the study. Findings and conclusions are summarized and presented

in this chapter. Also presented are the interpretation of the findings as related to the research questions and propositions. Chapter five provides interpretation of the results based on the review of the topic, as shown in terms of research capabilities. This chapter illustrates further limitations that emerged during the study. Also, this chapter covers further implications of the practice and relevance for practitioners in the field. Suggestions for future research and the provision of guidance for future research studies on the topic are discussed.

CHAPTER TWO

This literature review covers the process of communication between managers and subordinates and its impact on effective decision making. There is a wide array of literature on error prevention, and that literature has shown the effects of insufficient communication (Frydenber, & Brekke, 2012; Kiston et al. 2013). Supported by the literature, the context of the research problem was the lack of communication between managers and subordinates, which leads to ineffective decision making (Fagerlin et al. 2011; DeHerrera, 2013 and Shellia, 2013). This review outlines the research problem, which explored communication problems between managers and subordinates in healthcare, specifically home healthcare. The literature review also covers the use of Situation Background Assessment Recommendation (SBAR) and Quality Assurance and Performance Improvement (QAPI), both of which can potentially be used to establish improved communication and coordination in home healthcare facilities. Descriptions of both processes are provided in the literature review.

Research has indicated that ineffective communication in the healthcare industry provides devastating outcomes, such as medical errors and patient harm (Woolf et al. 2004). Encompassing the contribution and attribution of different conceptual frameworks such as Human Relations Theory, System Theory and Communication Relations Theory, this research helped link the need for active communication with effective healthcare outcomes. These concepts are influencing theories that have guided the process of basic communication and decision making (Cyert & March 1963). Trends have occurred from the 1930s through the 1960s that have drawn theorists to individual needs of employees, social interaction, and individual achievement as communication factors (Miller, 2006).

The research derived from Communication Relations Theory. Furthermore, it was built upon the healthcare management concentration, using theorists such as Herzberg (1959).

The Human Relations Approach concentrates on communication between people about both work and social topics. Because individuals work on their own in-home healthcare, effective relationships among staff members is extremely important to the efficiency of the organization. According to Eckelman & Nasiri (2011), Systems Theory applies to any system in life, which includes how the family operates or the way a hospital provides healthcare services. Systems are thus a group of individual parts that work together, employing communication to enhance the effectiveness of the whole (Eckleman & Nasiri, 2011). The attributes of Systems Theory can provide home healthcare employees a model of communication within the industry. Zeitz et al. (2011) examined the communication disconnect in healthcare, noting that effective communication was needed to create a collaborative effort and proper treatment. There had been an opportunity within healthcare management to understand the nature of this disconnect and establish a more efficient communicative environment. This research was necessary to provide accurate treatment and safety in home healthcare facilities (Parks, 2011). Ideally, this study will contribute to the overall knowledge base about communication practices in the home healthcare industry.

Overview of the Literature Reviews Section

This literature review provided substantial literature to explore the problem statement and lack of coordination of care through communicative methods in home healthcare. It also covered extensively the purpose of this literature review, which was to incorporate communicative methods and to encourage home healthcare improvement.

Primary insight into the problem and purpose, as well as proposed questions, led to applicable methods of communication: QAPI, and SBAR. These methods are beneficial to healthcare providers as they explore and implement methods to solve communication deficiencies.

With the Patient Protection and Affordable Care Act (PPACA), there have been increasing methods that have offered strategies to improve the quality of care in medical industries. For example, the Health Information Technology for Economic and Clinical Health Act (HITECH) allows for incentives through Medicare and Medicaid to clinicians and hospitals (Parks, 2011). However, there was a need for further study in the area of communication in home healthcare, which has become a major industry. Due to financial considerations and costs, proper communicative methods, such as SBAR and QAPI, may not be in place for home healthcare (Rentz, et al. 2013). The issue that remains is allowing communicative activities in facilities to combat and address concerns of safety and morbidity. According to The Joint Commission (TJC, 2012) report, home healthcare facilities have a difficult time providing transaction of care between long-term care, behavioral healthcare, and home healthcare. Also, research was required to understand proper methods of communication between health advisors and patients to allow for smoother end-of-life transitioning (Shannon, et al. 2011). This study presented communicative methods like QAPI and SBAR, which have been helpful in other industries. Moreover, information on QAPI and SBAR suggested managers may use them to bridge the internal communication gap. For instance, QAPI can be used to link managers' and subordinates' understanding of quality and patient care. According to The Centers for Medicare and Medicaid Services (2013), the aim of QAPI is to create a team

environment by supporting members' creativity in communication. This process is also known to establish collaboration through shared development of communication and coordination of care (CMS.gov, 2013). According to the Institute for Innovation and Improvement (NHS, 2008), SBAR can be helpful in clarifying managers' and subordinates' perceptions. The NHS (2008) reports that using SBAR can help shape communication at any stage, especially where staff may be uncomfortable about making recommendations. TJC (2013) found that SBAR can increase communication and productivity through standardization of uniform messages for the facility or the organization.

In selecting these communication methods, SBAR provides quality and patient safety, which helps individuals communicate with each other with shared sets of expectations (Rentz, et al. 2013). SBAR integrates several safe communication strategies into the organizational culture, most notably teamwork, psychological safety, and open and active communication (Novak & Fairchild (2012). SBAR utilizes practice worksheets to engage team members in discussions of human factors concepts, leading to direct communication. According to the Office of Disease Prevention and Health Promotion (ODPHP) (2015), efficient use of communication has many implementations that include: (a) Improved healthcare quality and safety; (b) Increased efficiency of healthcare and public health service delivery; (c) Improvement in public health information infrastructure; (d) Supportive care in the community and at home; (e) Facilitation of clinical and consumer decision-making and; (f) Incorporation of health skills and knowledge.

The American Association of Colleges of Nurses ACHA (2015) defined QAPI as a process that delivers high-quality care, a sound monitoring and evaluation process against evidence-based standards of care, and improved outcomes. A study of the impact of communication in healthcare management was conducted by the Institute of healthcare Communication in (2013). This study found that there is an opportunity to improve ineffective management and clinician communication. Additionally, the study indicated that the ineffectiveness of communication leads to increased malpractice risk, non-adherence, patient and clinician dissatisfaction, and poor patient health outcomes. Thus, ineffective communication emphasizes the necessity for addressing the management of communication skill deficits within the medical industry. The research uncovers proper communicative methods in this industry. SBAR promotes better communication through presenting a formula that illustrates understanding the situation, sharing background information, joint assessment of the issue, and shared recommendations for medical outcomes (Flemming, et al. 2013). For example, nurses at major hospitals have used SBAR as a method to turn over relevant information during their shifts (Narayan, 2013). QAPI is useful in tracking data on a monthly basis by a member in the department. For example, through an establishment of committees, QAPI can be used to look at industry trends such as communication and how to establish better communication and coordination of care.

Home Healthcare Management

The healthcare home model was endorsed by the American Public Health Association in 2010. The goal of this model was for primary care communication to contribute to increasing access to care, reduction of health disparities, and better

integration of public health systems (Grant & Greene, 2012). Grant and Greene (2012) summarized the elements of the healthcare home model by providing evidence for its clinical and public health needs. The authors also demonstrated the place within the context of healthcare reform where legislation is required. Bao et al. (2013) opined that the legislation of home healthcare has been seen in the linkage of social supports and the enhancement of social support and coordination of medical and behavioral healthcare.

History of Home Healthcare

Home or "home nursing" was first used in the late 1800s by a group called the Ladies Benevolent Society (LBS). Since then, coordination of care has primarily resided in the health facilities (Murkofsky & Alston, 2009). However, in the past 20 to 25 years, care coordination has shifted to home healthcare providers (Murkofsky & Alston, 2009). According to the Agency for Healthcare Research and Qualities (2015), Like most industries, home healthcare is reliant upon technologies for effective communication of medical issues and concerns. The use of technology along with QAPI and SBAR can create an environment that improves the exchange of information among the staff in an efficient manner (Coleman, et al. 2007). A report by the US Department of Health and Human Services in 2007 stressed the importance of technological enhancements to establish home healthcare coordination of care further, through better communication.

System Relations Theory

Ludwig von Bertalanffy developed General Systems theory in the 1940s. This method, as explained by Shaked & Schechter (2013), improved the ability to advocate for thinking about any situation. It also provided emphasis on relationship components among individuals in the work environment. This process helped communicators to

understand power and influence within inter-group relationships and changes involved in planning development activities (Tamas, 2010). Like families, organizations that do not communicate properly often break down, and this breakdown is evidenced by the occurrence of inadequate direction, decisions, and health problems. Too much concentrated power can be harmful; however, if properly shared, this power can help organizations grow (Tamas, 2010). According to Littlejohn (2001), a system can consist of three things. First, systems are processed by elements and variables within the infrastructure of the system. Next, a system consists of attributes and qualities or properties of the system and objects by involving internal relationships among those objects (Littlejohn, 2001). Lastly, systems use conceptual models to support healthcare through an environment that encourages input, transformation, output, and communicative feedback (Littlejohn, 2001).

Senkubuge et al. (2014) conducted a study on system thinking that presented the five points of interactions regarding health sector reforms and country health systems. Senkubuge discovered these five point systems are governance, finance, health workforce, health information systems, and supply management systems.

Human Relations Theory

The notion of Human Relations Theory accounts for individual needs, whatever they may be. Human Relations Theory, developed in the 1920s and 1930s, is also helpful in understanding the lack of communication among groups of individuals. This theory speaks to the notion that employees are motivated by more than just financial gain, but many other factors (Conrad, et al. 2015). According to Resuscitation Council RCUK (2011), 80% of adverse incidents or near-miss reports in hospitals are due to

communication problems. For instance, incidents can occur when staff members work different shift patterns and are unfamiliar with each other or their team's skill mix. In home healthcare, the relationship is often driven by communication, emphasized through the Human Relations Theory.

Communication Accommodation Theory

Another important theory that supports active, communicative relationships is the Communication Accommodation Theory (CAT), which was formulated in the early 1970s by Henry Giles. According to Giles (1970), CAT attends to an essential element of human relationships. It speaks primarily to the adjustments needed in communication patterns, about each member. This method highlights the processes of convergence and divergence. Giles (1973) explained that convergence allows for adaptation, which reduces social differences. In healthcare, this process is important because it helps healthcare managers establish elements of communication regardless of an individual's characteristics. Conversely, divergence applies to those social and nonverbal differences that medical professionals encounter. This measure informs healthcare personnel about the behavior patterns and methods used to communicate (Giles, 1973). Regardless of the situation, the healthcare manager must be willing to accommodate the flow of communication and interaction to allow for appropriate relationships among and contributions from the staff (Giles, 1973).

Related Studies and Theories

Previous health systems, such as the Department of Veterans Affairs (VA), are prime examples of how adverse communication among staff has led to poor decision-making processes, poor employee morale, and inadequate patient care. According to

Rhodes (2013), there are four stages of interaction among team members: starting a conversation, creating interest, making a connection, and encouraging the other party to take action.

Although all organizations use interaction as an essential part of communication, healthcare services base their industry on interaction through the provision of honesty and respect, which creates an environment of communication (Rhodes, 2013). Honesty is seen as a platform in which communication and decision making are introduced. Without this honesty, respectability cannot be given, shown, or returned (Rhodes, 2013).

Similar Studies and Research Methodologies

Pype et al. (2014) produced a study on primary palliative home healthcare. This study used cross-sectional design to understand collaborative practices among nurses, General Practitioners (GP) and Primary Home Healthcare Teams (PHCT). The research presented the following questions: (a) What do GPs and PHCT nurses learn during collaborative practice? (b) How do GPs and PHCT nurses learn during collaborative practice? (c) From whom do GPs and PHCT nurses learn regarding this medical practice?

This study concluded that learning occurs through inter-professional collaborative practices in primary palliative care (Pype, et al. 2014). Bramberg and Sandman (2013) examined how home healthcare providers and social workers use communication to alleviate common language barriers and Bramberg and Sandman suggest helpful methodologies. This qualitative study used explorative and descriptive measures to induce content analysis through focus group interviews. A study conducted by Price and Lau (2013) interpreted continuity as the essential aspect of quality of care for complex

patients in the community. The circle of care was introduced as a methodology that explored soft systems through communication measurement. Discussion groups and interviews were the primary tools used to understand patterns that support communication (Price & Lau, 2013). For this study, the theoretical population were managers and employees of home healthcare facilities in the Arlington/Fort Worth metropolis. Accessibility to the population included two home healthcare organizations in the area of 20 home healthcare facilities and clinics.

Healthcare Communication Methods and Technology

Situation Background Assessment Recommendation (SBAR)

SBAR is a communicative method that was established by the U.S. Navy to facilitate the gap in communication between military members. SBAR is now a communicative technique that has been adapted by major healthcare facilities around the country. Home healthcare has a need for methods that enable these expectations to be shared, creating a provider-to-client connection and regarding loved one's health (Parks, 2011). The studies that follow are examples of how this procedure has been used to ensure professionalism and coordination through proper communication.

Wacogne & Diwakar (2010) examined the implementation of the SBAR communication approach, which is aimed to mitigate surgical morbidity and mortality. This study mentioned that communication failures caused 11% of preventable adverse events leading to permanent disability in Australia. It also noted that the SBAR approach is among the various recommendations of the World Health Organization aside from the Surgical Safety Checklist.

Boaro et al. (2010) examined the use of SBAR for the improvement of inter-professional rehabilitation team communication. This research team noted that the SBAR popularity and uptake made it the best practice in various acute care hospitals in the U.S. It described two examples that show the benefit of the SBAR tool in team communication.

Cunningham et al. (2012) explored whether exposing junior doctors to SBAR improves their telephone referrals. SBAR is a standardized minimum information communication process. Hospital interns from a 2-year period (2006-2007) participated in two simulated clinical scenarios that required them to make telephone referrals (Cunningham, et al. 2012). This study contrasts the outcome of SBAR, stating that it improves telephone referral performance by increasing the amount of critical information presented. However, Cunningham (2012) showed SBAR improved the "call impact" of the telephone referral as measured by qualitative global rating scores (Cunningham, et al. 2012).

According to Fay-Hiler et al. (2012), TJC found that 65% of medical errors and medical sentinel events are due to communication breakdowns. Fay-Hiller et al. (2013) also noted that the Institute of Medicine recommended improvement in the following healthcare competencies: education, communication, collaboration, and a patient-centered approach to providing safety. Also, Fay-Hiller (2013) suggested that students should have an opportunity to practice communication and collaboration skills while obtaining clinical experiences. The potential solution was proposed by the structured SBAR communication techniques, which were found to improve patient safety in healthcare environments (Fay-Hiller, 2013).

Shannon et al. (2011) opined that communication skills are the key in quality end-of-life care, including the critical care setting. Generally, transferable communication skills, such as therapeutic listening, have been common in nursing education. Moreover, specific communication methods have been the norm for medical education. Shannon et al. (2011) determined it is now time for critical care nurses to benefit from learning communication tools that are specific to end-of-life care. This study demonstrated the Ask-Tell-Ask, Tell-Me-More and SBAR methods. These tools practiced using a case of a family member who believed that treatment is being withdrawn prematurely from the patient. Shannon et al. (2011) found that these communication methods offer nurses new strategies for approaching potentially complicated and emotionally charged conversations. Ask-Tell-Ask reminds nurses to assess concerns carefully before imparting information. Tell-Me-More provides a tool for encouraging dialog in challenging situations. Finally, SBAR can assist nurses to distill complex and often long conversations into concise and informative reports for colleagues (Shannon, et al. 2011).

According to Rentz et al. (2013), ineffective nurse-physician communication in the nursing home setting harms resident care as well as the work environment for both nurses and physicians. Rentz et al. (2013) explained that using a repeated measure design, this quality improvement project evaluated the influence of SBAR. In this study, the use of SBAR enabled nursed to communicate better, in terms of lifting communication barriers.

SBAR connection to home healthcare can be understood through current trends, which includes adverse events that occur while a patient is transitioning from hospital to the home healthcare environment. A study conducted by TJC (2013) showed that 80% of

patient issues occur due to misunderstood communicative errors and ensuing consequential events. These errors were substantiated in the improper transitioning of patients. These issues usually occur when patients leave the hospital and go to other medical facilities, such as adult living centers, assisted living and home healthcare environments (TJC, 2013). SBAR is thus relevant to the provision of proper communication inside and outside the medical industry. To accept this process means reducing readmission rates and other issues, and improving transitioning from hospital to home healthcare facilities.

Quality Assessment and Performance Improvement (QAPI)

Taliani et al. (2013) found growing evidence that practice-based care management can improve clinical quality and reduce costly healthcare utilization. This research explored a disparate group of patient-centered homes to understand best practices that can enhance communicative efforts. The results showed that in creating the best measures of practices, the organization must provide an increased measurement of communication. Moreover, patient-centered care manager duties, establishing the better use of the electronic medical record (i.e. messaging and patient tracking), as well as enhancing integration through care teams are needed. Enhancement in these measures will help improve patient health issues such as diabetes (Taliani, et al. 2013). This study showed how QAPI can be helpful in managed care. For instance, availability adds to patient support, self-management, and patient tracking. It also ensured integration into the care team with ongoing communication (Centers for Medicare and Medicaid Services (CMS). gov, 2015). To illustrate how QAPI can work in the home healthcare industry, five elements of this method are listed below as indicators (CMS.gov, 2015).

First, design and scope can help smaller institutions, such as home healthcare facilities, to create a high quality of clinical intervention. Design and scope are necessary because a higher level of clinical response leads to a higher level of patient safety while still emphasizing some degree of autonomy (CMS.gov, 2015).

The process of governance and leadership is essential in any industry. To the home healthcare industry, governance means having the utmost accountability. Communication is thus a major component that ensures each employee receives management, equipment, and technical training as required (CMS.gov, 2015).

Another element under QAPI is the provision of data systems and monitoring. Staff in any organization should be given every opportunity to create a situation of feedback, data systems, and control. QAPI includes measurement and input from staff, residents, families, and other appropriate individuals. The author states this element provides for a full range of care processes and outcomes because users of QAPI review findings against benchmarks or targets that affect the facility (CMS.gov, 2015).

A performance improvement project may relate directly to efficient communication by gathering information and systematic clarification (CMS.gov, 2015). Performance improvement projects are crucial when organizations need a measurement tool to clarify issues and problems that can be improved upon (CMS.gov, 2015).

Effective Feedback Helps Communication

Effective teams give feedback and review regularly to determine if they have achieved their objectives (Walker, 2008). Providing feedback after events can improve members' self-awareness. It can encourage the most dominant members to listen more and the quieter members to become more involved. This method, according to Walker

(2008), created an environment that led to shared decision making. Significant studies such as Huitt (2007) and Franken (2001) provided valuable insight into employees' need to communicate optimal job involvement. Hospitals, as well as home healthcare facilities, preclude communication through variables such as proper beds, client rest, cleanliness, reassurance, response and family needs (Della Pietra, 2013). Managers can create an environment that establishes employee success. Success is rewarded through a system that fulfills certain fundamental needs. If this system of compensation is not maintained properly to maintain social needs, that system will cease to exist. Norwood (1999) opined that communicative feedback leads to the development of coping, enlightenment, empowerment, and open communication. Feedback is critical to home healthcare because healthcare professionals must be aware of sensitivity, and attitudes, needed for communication, may contribute to future advances in developing the communication skills and knowledge of nurses. As healthcare professionals are still the primary source of information before surgery, they need to be prepared to meet their patients' needs. Patients had different feelings about information, like getting upset or anxious when learning about a cancelation, feeling cared for when they received reassuring information from medical professionals, and confused if they could not get what they wanted.

Shellia (2013) conducted a study of the impact of communication in healthcare management. According to Shellia, there is further opportunity to improve the ineffective management of clinician-patient communication. Miscommunication often leads to increased malpractice risk, non-adherence, patient and clinician dissatisfaction, and patient health outcomes (Shellia, 2013). All these issues emphasize the necessity of

addressing the management of communication skill deficits (Shellia, 2013). Batet et al. (2012) produced a study that looked at knowledge-driven delivery of home healthcare services. Batet proclaimed that home healthcare assistance is emerging as an effective and efficient alternative to institutionalized care. In the case of senior patients who present with multiple co-morbidities and require life-long treatments under continuous supervision, it is especially relevant.

Past studies have looked at the views and experiences of clinicians who used triadic communication in pediatric consultations. A recent survey performed by Christie et al. (2014) talked about the effectiveness of triadic communication for antibiotic use in the care of acutely ill children. However, little has been studied about home healthcare communicative methods, which may increase safety procedures. Through this study, the gap in knowledge can be addressed and considered in this area for better understanding.

Mendell (2014) stated that communication is about the vitality of the issue stated or given. Mendell distinguished this statement further by looking at differences between causal relationships and mere happenstance or correlations in his study. This study provided for the relevance and necessity of communication in every field, especially media (Mendell, 2014).

Fagerlin et al. (2011) presented the notion that lack of communication establishes risk, and can only be produced accurately through everyday language communication. Fagerlin et al. (2011) opined making informed health decisions allows patients to understand and recall risks, which involve ratios and denominators. However, the process can be complicated, exposing the patient to information that may not be helpful (Fagerlin, et al. 2011). Managers and leaders in organizations have the ability to provide factual

information through proper communication (Garcia & Galesic, 2011). Daniel et al. (2014) talked about a recent Institute of Medicine report, which concluded that patients desire to include themselves in the decision-making process. This participation is evident what patients want, and what they receive. Through active communication methods, crucial identification of harms and injuries create benefits. Alston et al. (2012) opined learning healthcare systems can deliver patient-centered care, through the establishment of coordination of care and communication. Alston et al. (2012) found that the theory of shared decision making helps integrate the patient's goals and concerns with medical evidence. Alston suggested proper communication and achieved high-quality medical decisions.

According to Batet (2012), home healthcare is a staunch alternative to institutionalized care; it provides care for elderly patients who face co-morbidities and life-long treatments under continuous supervision. This article helps to understand the need for specially tailored treatments and coordination of a team of professionals from different institutions that require communication and building of knowledge, such as medical, organizational, social and procedural. Batet (2012) focused this article on (a) assistance to physicians in regards to defining a customized treatment and; (b) tailoring profiles of care professionals.

Carroll (2012) talked about the 5As of communication intervention: ask, advise, agree, assist, and arrange). These five communication methods can be used to create understanding and collaboration for health behavior counseling in primary care. In this study, a recommended design included a pilot trial, examining a central care clinician communication intervention in two groups. The results reported from the two groups

showed that the 5As of communication were effective in linking community resources for physical activity promotion for underserved groups. This study can be beneficial in home healthcare, through the coordination of care and communication.

Depuccio & Hoff (2014) explained that medical home healthcare is becoming a model for the application of primary care delivery, through quality and safety outcomes. In this study, Depuccio & Hoff (2014) addresses two important questions. First, are quality and security issues associated with medical home healthcare? Next, what is the relevance of patient-centered interventions through communicative analysis, regarding older adult primary care?

According to Hobbs & Rivera (2014), any home healthcare situation must provide patient and family engagement, quality, and safety in healthcare. Effective teamwork is widely known to be critically important to healthcare outcomes. The guiding thought is that at any base of patient practice should be patient family engagement through proper communicative methods as well as active healthcare teams.

According to Hobbs & Rivera (2014) the consideration of patient and family involvement has been treated more as a supplementary tool or input for professionals, external to the healthcare team. Hobbs & Rivera (2014) opined only recently that conceptual models have included patient and family engagement as a factor in improving health outcomes, patient safety, and quality of care. Hobbs & Rivera (2014) believed that further study is required for the integration of teamwork and patient and family involvement. This study would examine benefits, limitations, and broader implications for healthcare human factors research and the healthcare system (Hobbs & Rivera, 2014).

According to Koh et al. (2013), a study for Health Literate Care Model would weave health literacy strategies into the care model. Kohn et al. (2013) stated that communication is prevalent in adopting health literacy, which would infuse planning and operations. Also included are self-management support, delivery system design, shared decision-making support, clinical information systems tracking, plan patient care, and helping patients access community resources (Koh, et al. 2013).

Levinson et al. (2010) opined that increased patient satisfaction is invested in the delivery of patient-centered communication skills. The PPACA is a process that may help if given the time. Providing proper communication methods has proven to have a positive impact on patient satisfaction, treatment adherence, and self-management (Levinson, et al. 2013). According to Levinson, et al. (2013), physicians have limited training on communication processes. To move forward, he suggests that those who make policies should also implement training grants, pay incentives, and certification requirements to enhance and reward effective patient-centered communication (Levinson, et al. 2013).

Marcel et al. (2012) examined communication channels for in-home service provision. This article focused on the joint effect of converging trends: the increase of in-home services, and the degree of customer participation. According to Marcel et al. (2012), the client's desire for communication is a trend in in-home service productions. This required communication is seen across all industries, especially healthcare, and more recently, home healthcare.

Price & Lau (2013) explored the perceptions of continuity through a system's approach. By doing so, they reviewed the circle of care, which employed Soft Systems Methodology. Soft System Methodology is used to understand and improve continuity

for end-of-life patients. According to Price and Lau (2013), there are four types of continuity: information, management, communication, and relationship. The Soft Systems Methodology model will provide further insight into communication, and its effects on continuity and systems approach, for the home healthcare environment.

Schultz et al. (2013) provide a systematic review of care coordination that recognizes the importance of high-quality healthcare delivery. Schultz et al. (2013) offer a view of how this process is important in establishing improved communication and coordination. There has remained little understanding of how best to facilitate measures of care and coordination. According to Schultz et al. (2013), the aim is to examine existing standards of communication and care coordination processes in order to identify areas of high and low density to guide future test development.

Trugilo-Londrigan (2013) conducted a study of shared decision-making in home healthcare from the nurse's perspective. According to Trugilo-Londrigan (2013), there have only been a few studies that have explored and described the elements that make up shared decision-making in home healthcare from the nurse's perspective. The results of this study are is essential to understanding shared decision and methods of delivery. Trugilo-Londrigan (2013) stated that future studies may require more comprehensive understanding of communication and shared decision-making in home healthcare practices.

Barriers to Communication

The research looked at the barriers to communication and teamwork. Barriers left unhinged can have several unfortunate consequences, most notably staff members feeling unsupported, which could lead to misunderstandings and resentment that could ultimately

hurt patient care. Restrictions create crisis management for both individuals and staff and teams (Dingley et al. 2008). So it remains important to look at this in terms of how decisions are made with barriers and constraints. It has been observed that barriers to communication have been detrimental to patient safety, staff morale and productivity (Henriksen et al. Eds.). The concept requires making time to look at why these barriers are in place (Dingley et al. 2008). The upside is the establishment of communications systems that are beneficial to the entire organization. Hunt (2014) states that effective communication is a process that involves team members in decision making.

Other barriers to communication are individuals' perceptions of themselves and the perceptions others have of them (Luft & Ingham, 1955) conducted a significant study in decision making in which they established that clarity is achieved through understanding, commitment, and creativity. This study conclude that clarity is the goal of communication (Natemeyer & Hersey 2011).

According to Bramberg and Sandman (2013), home healthcare is, at times, very diverse in nature. The use of interpreters is essential for successful communication, which provides equal access to healthcare for all patients (Bramberg and Sandman, 2013). This study, which was explorative, qualitative, and descriptive in nature, concluded that there is a need for an interpreter as an active participant in communicative practices. Bramberg and Sandman (2013) viewed interpreters as an essential part of the care team, because they aided in decreasing the possibility of threat and patient confidentiality. Moreover, their participation in the care team could contribute to solving the problem of interpreting the patient's non-verbal signs.

According to Davis et al. (2012), patients are vulnerable to poor quality and fragmented care as they transition from hospital to home. Davis et al. (2012) determined that only a few studies have examined the discharge process from the perspectives of multiple healthcare professionals. Davis et al. (2013) concluded that inadequate transitional care and fragmented communication led to poor communication within the hospital. Also assessed were chaotic and unsystematic transitions, small patient outcomes, and negative feelings of futility, as well as providers' dissatisfaction. Particularly affected were patients with complex psychosocial needs during care transitions. Davis et al. (2013) emphasized the importance of this finding in terms of the hospital to home healthcare changes, which are critical to health outcomes, the experience of care, and costs.

Frydenber and Brekke (2012) found that poor communication about patients' drug use affects patients across healthcare levels. The author wanted to determine if inadequate communication leads to errors in patients' medication upon admission, during hospital stays, and after discharge. In their study, they also sought to gauge whether these errors were potentially harmful. According to Frydenber and Brekke (2011), the majority of medication errors are made during admittance to the hospital, where communication is vital.

Hardy and Jaynes (2011) examined the need to improve healthcare safety and quality through better communication. The authors highlighted the high incidence of medical errors and safety incidents and the failure to achieve the goals of various quality programs. Hardy and Jaynes (2011) argued that establishing a culture of safety, quality,

and humanity requires an understanding of the individuals forming that culture through extensive communication.

Kitson et al. (2013) suggested medication errors are common, with preventable errors in healthcare causing unnecessary patient harm, hospitalization, and, at times, fatality. Improving communication between each member of the team and patients is essential to improving patient safety and decreasing medication errors (Kitson, et al. 2013). Kitson et al. (2013) opined management of care requires collaboration and communication across each sector of care, which can reduce (or contribute to) medication-related errors.

According to Morténius et al. (2012), proper methods are needed to bridge the gap between theory and practice. These methods can help promote positive attitudes among healthcare professionals and facilitate the incorporation of new research findings. According to Morténius et al. (2012), communication plays a significant role in analyzing primary care staff members' readiness to adopt new ways of thinking. Communication also plays a role in staff members' willingness to utilize strategic communication to change their work practices. The authors concluded that strategic communication plays an imperative role in the process of creating innovative attitudes and behavior among primary care professionals. For success, the authors suggested that those professionals must be willing to change attitudes. Morténius et al. (2012) also suggested that communication will enhance primary care professionals' readiness to change everyday practices by implementing evidence-based care.

Spitzberg (2013) stated the central role of effective communication in the healthcare industry is to provide contemporary accounts of efficient healthcare delivery.

Moreover, Spitzberg explained, effective communication provides the communication of medical error explicitly, which no commonality or consensual core in the health professions regards the same outcomes. According to Spitzber (2013), the relationships among the integrative models of communication competence are conceptualized, along with theoretical background and rationale. Spitzberg (2013) opined that communication competence is an impression of appropriateness and effectiveness, which relates to knowledge, skills, contextual facilitators, constraints, and individual motivation.

Stone et al. (2013) note the importance of further study of the successful implementation of Gold Standard Framework in Care Homes (GSFCH) program. This program's purpose to develop the quality of end-of-life care for older people living and dying in care homes. According to Stone et al. (2013), communication is a major factor in the integration of Advance Care Planning (ACP). To create adequate experiences, GSFCH employs the development of medical professionals' knowledge, skills, and confidence to engage in discussions about end-of-life care. Stone et al (2013) recommended further research and follow-up training for the initiation of communicative care in home healthcare.

Summary of Literature Review

The literature review was divided into five sections and a summary. The first section provided for the process of communication and coordination, describing the opportunity, issue, and required methods for communication and coordination of home healthcare. Sub-sections included in the first section explored similar studies and research methods, and the home healthcare management environment. Part two of section one described the history of home healthcare, summarizing contributions to home

healthcare, impactful studies, and collaborative learning. Part three of section one introduced communication proponents and barriers to communication.

Section two of the literature review focused on communicative methods to include healthcare communication methods. These tools of communication included the usage of SBAR and QAPI. Part one of section two covered the function of communication methods: increasing communication, improving the decision-making process, and creating an opportunity for shared decision making. Parts two of this section included effects of QAPI, and SBAR. Section three was comprised of the conceptual framework. This section looked at the guiding theories of home healthcare communication and focused on Human Relations Theory and Communication Accommodation Theory. Final sections were four and five, measurement and findings, respectively.

It is important to understand through this study that more information should be provided about the effects of communication upon the home healthcare sector of the healthcare industry. This effect is most apparent in the processes of decision-making outcomes. The literature covered the inefficiencies of communication, which is a major issue throughout healthcare industries and organizations. It is important to understand the actual framework of communication, and how it helps industries. This structure, as explained by Human Relations Theory, Systems Theory, and the Communication Accommodation Theory, leads to positive outcomes in decision making. According to the Resuscitation Council (2011), 80% of adverse incidents or near-miss reports in hospitals are due to communication problems. This study involved two home healthcare organizations, which provided understanding of the communication issue.

Based on the review of the literature, the proposed research is identified as exploratory and nascent. Although previous research has been done on communication and its effects on decision making in major organizations, little has been presented on its impact in home healthcare. With home healthcare becoming a leading source of care in the aging population, the current study looked to explore this growing segment of healthcare. Furthermore, methods such as QAPI and SBAR can establish an environment that is efficient and that has benefitted from improved decision making.

Home healthcare started in the early 1980s and is presently taking on an increased role in the healthcare industry. Guiding theories such as Communication Accommodation, Systems Theory, and Human Relations Theory, provided a framework for the successful practice of home healthcare communication and coordination of care. These concepts and methodologies look to the present and establish communicative contributions to the medical field.

Chapter three contains the rationale and plan for the research while providing the tradition and design of the study.

CHAPTER THREE

This chapter describes the rationale for a qualitative design based on the methodological tenets of the phenomenology of home healthcare providers and the communicative methods employed by management. The purpose of this phenomenological study was to understand interdisciplinary communication between home healthcare managers and healthcare providers in a small facility. Specifically, it looked at home healthcare facilities while determining proper communicative methods for these facilities. The research problem in this study addressed a lack of communication between managers and subordinates, which leads to ineffective decision making. This issue pertains to the communication relationship between healthcare providers and administrators. Such problems lead to inferior outcomes and decision making (Bambert & Sandman, 2013; Frydenber & Brek, 2012; Hardy & Jaynes, 2011 and Spitzberg, 2013). With members of the so-called baby boomer generation aging in the United States and as the demand for in-home healthcare increases, the challenge for communication poses a significant test for the healthcare industry. This study used empirical data derived from semi-structured open-ended interviews.

The design chosen for this study was phenomenology, which focuses on how individuals make sense of the world around them (Bryman & Bell, pp.18, 2011). Another purpose of this study was to explore the lived experiences of home healthcare personnel and the communication methods used to promote effective decision making. Understanding the lived experiences of medical professionals enhanced the knowledge about how healthcare administrators deal with communicative factors and issues in proper communicative methods.

Existing research has shown the need for effective communication for the purpose of safety and quality for patients and providers. Interpersonal rehabilitation and communication enlighten patient satisfaction (Abusalem, 2013; Bertland, et al. 2012; Boaro, et al. 2010). Little qualitative study has been dedicated to the need for better communicative methods in home healthcare. This study intended to address the gap by gaining in-depth understanding of managers' behaviors and actions promoting communication methods for employees.

Chapter three consists of a discussion of the research tradition, which is a qualitative analysis. Also covered in this chapter are research questions and propositions, research design, population and sample, sample procedures, instrumentation, credibility, trustworthiness, data collection, data analysis and ethical considerations. Research questions were used to enhance the understanding of communication and methods used to enrich effective decision making. To conclude, chapter three provides a discussion of the research design and summary of the chapter.

Research Traditions

The approach chosen for this study is qualitative for many reasons. The purpose of this phenomenological study was to understand interdisciplinary communication between home healthcare managers and healthcare providers in a small facility. Qualitative data analysis provides the ability to collect, analyze, and use the information to improve communication in medical organizations. Qualitative research was warranted because the research required exploration (Creswell, 2009). Qualitative research questions often begin with how or what, which helps to gain in-depth analysis and understanding of the topic (Bryman & Bell, 2013). Moreover, this study investigated

participant experience with communication in medical facilities that impede decision making. Secondly, the qualitative approach offered a means to explore phenomena and the feelings that interviewees express. Moustakas (1994) conducted a phenomenological study, exploratory in nature, to understand the lived experience of medical professionals at award-winning hospitals that maintain upward communication, which is the process of information flowing from the lower levels of a hierarchy to its upper levels (Adelman, 2012). Moustakas produced a landmark study, which appropriately demonstrates ethical and practical concerns of communication within primary healthcare facilities, specifically smaller institutions.

A qualitative research design was appropriate to explore and understand a social phenomenon of the lived experiences of healthcare providers who struggle with communicative methods (Wheeler, 2014). The nature of the study indicated the best method for the study would be a qualitative phenomenological research design, which is less structured and provides more flexibility than a quantitative study does (Creswell, 2014). The design also offered an open-ended approach that allowed for more questions to be asked of the participants based on their responses. The research goal was to obtain detailed information about the phenomenon, not restrictive answers to close-ended, or yes-or-no, questions about the experiences (Rubin & Rubin, 2012). The phenomenological research design was appropriate for exploring the influence of negative communication on healthcare industries and outcomes. Using the phenomenological design to interview healthcare providers established a level of understanding of the perceptions of communicative practices and resources needed.

This research intended to show that healthcare in general, and specifically healthcare management in healthcare facilities, can benefit from studying this issue. This research was nascent in nature. The following are examples of similar phenomenological studies.

Adelman (2012) conducted a study that was exploratory, utilizing a phenomenological collective case study approach. Adelman (2012) stated that research is required to produce collaboration between administrators and clinicians, and enforce organizational learning and sharing of information. The premise of this study was to understand the lived experiences of individuals surrounding employee voice and upward communication. Using phenomenology, as suggested by Adelman, allows insight into leadership behaviors in terms of promoting employee voice and upward communication. Adelman (2012) provided in-depth descriptions of CEO actions and reactions to understand the phenomenon of employee voice and critical upward feedback. This study was exploratory in nature; this research is needed to build a framework to link the how and what for effective communication methods in healthcare (TJC, 2013). Newer studies in this area are vital to understanding the lived experience of the home healthcare community, and to build a bridge to communicative traditions.

The research design that is well suited for the topic of communication in healthcare was based on questionnaires and personal interviews. As a qualitative study, this research achieves deeper understanding of communication methods in home healthcare. Questionnaires and personal interviews remain the method of choice in many of the studies that have been conducted to explore communication methods in the healthcare industry. The characteristic of this subject relates to explanations of treatment

in home healthcare, based on the lack of communication methods in home healthcare. The main character of this research pertains to the qualitative methodology of questioning the intimacy of communication in particular circumstances relating to human healthcare. The study was exploratory and nascent in nature, allowing deeper examination of the study participants and their social structures. As a qualitative study, this research was intended to understand how individuals construct their worldview. Additionally, this study is validated by building upon unmet solutions of other studies, which have used theories such as Communication Accommodation for measurement. Other models have provided insight into the need for communication and belongingness.

Research Questions and Propositions

The primary research question for this study was as follows: What are the lived experiences of home healthcare professionals regarding communication between managers and subordinates to facilitate patient care turnover?

The primary propositions in this study are as follows:

It was proposed that communication methods can be used to help promote better communicative practices in home healthcare facilities. It was also proposed that managers can emphasize communication through methods such as Quality Assurance Performance Improvement and Situational Assessment Background Recommendation.

Research Design

The philosophical worldview utilized in this study was constructivism, seeking to understand the experiences of participants in the environment in which they work (Creswell, 2009). The research design was based on semi-structured interviews as the method and primary tools of the study. Interviews were conducted using open-ended

questions and probes to obtain information. Trustworthiness was enforced by using coding, member checking, and triangulation. Credibility was checked by clarification of research biases and assumptions. Also, credibility was applied by the process of member checking. Reliability was gauged through presenting the same questions to each member every time, producing stable and consistent results (Rubin & Rubin, 2012).

A qualitative methodology allowed for exploration where little information was known about the problem. Moreover, fundamentals were not identified, and the need existed to understand the problem in question (Denzin & Lincoln, 2005). According to Creswell (2009), there are four characteristics of qualitative research: (a) focus on understanding and meaning; (b) primary data collection and analysis; (c) inductivity; and (d) descriptiveness. The qualitative methodology used in this study was phenomenology. According to Christen, et al. (2010) phenomenology explores the lived experiences of individuals and groups. Phenomenology can provide a means to uncover deep understanding of these experiences from the perspective of the individual actor or the group (Christen, et al., 2010). This study attempted to understand the communicative process through the eyes of the study participants. As proposed by Moustaks (1994), the research looked at the wholeness of home healthcare communication, as well as the essence of the experience.

Population and Sample

According to Trochim (2002), a study population can be defined in two ways: theoretical and accessible. The theoretical population research was used to create generalization (Trochim, 2002). The population was composed of individuals who were available for research. For this study, the theoretical population comprised managers of

healthcare industries and subordinates in the Dallas/Fort Worth metropolis. However, the accessible population was the suburb of Dallas, located in Arlington, consisting of 20 home healthcare facilities. The research drew from a sampling frame of home healthcare services in Arlington, Texas. Permission to access the sampling frame was granted by the administrators of two home healthcare organizations (Appendixes A and B). Findings were not to be generalized to other facilities in the area for this qualitative study.

Sampling helped ensure proper representation of the organization, and avoided sampling bias (Bryman & Bell, 2011). Throughout the study, selection of participants was based on the identification and inclusion of representatives from each department. Additionally, participants were chosen based on qualities and experiences that allowed for phenomenological questioning (Miles & Huberman, 1994). The study covered demographics to include gender, and occupations (i.e. administrative and clinical personnel). The study target sample size was 15 to 20 participants, with the understanding that prior research of this nature was consistent with this sample size. Moustakas (1994) noted that phenomenology involved studying a smaller number of subjects through extensive prolonged engagement to develop patterns and relationships. Similar studies from Creswell (2009) and Lucia (2010) used guidelines for phenomenological ranges from 5 to 30 and 12 to 15 participants, respectively. These studies suggested that researchers who conduct phenomenological studies have been successful with this sample size in determining desired experiences.

Sampling Procedure

Purposive sampling, using a snowball sampling technique, was used to understand the phenomena of communication and decision making. Snowball sampling allowed the

study to reach populations that were difficult to sample (Heckathorn, 2011). Communication can be accomplished by conversing with local administrators and establishing referrals. The study used a criteria sampling method. Sampling produced access to names in the population (Creswell, 2014). This procedure was done by: (a) defining home healthcare organization population; (b) listing the population of home healthcare providers; (c) determining the sample size; and (d) selecting the sample. By using criteria selection, each person in the organization had equal opportunity for selection. The goal was to use participants in the geographical area strategically, but not systematically, adding a measure of relevancy. The strategy of criteria sampling is to get additional information about personnel and select participants based on criteria. From this list, participants were selected based on established criteria. This process reduced the potential for human bias by using criteria selection of personnel for inclusion in the study (Byman & Bell, 2011). In turn, the research provided a sample that is valid and representative of the population.

Venter et al. (2005) provided another example of snowballing sampling usage by using snowball sampling in his research to look at the factors that influence succession processes in small and medium-sized family businesses. The intention of this study, as explained by Venter et al. (2005), was to access from large South African companies their mailing lists of small and medium-sized companies. However, large organizations may decline to share client information, so snowball sampling techniques can also be used efficiently. According to Venter et al. (2005), this process can prove useful if the initial contact is made with a group of people relevant to the research. Additionally, Venter explained it helped to establish further contact with others. In comparison to

previous studies, this study used snowballing as a referral process, to engage other administrators in participating in this research.

Instrumentation

Instrumentation used in this study included both researcher-completed instruments and subject-completed tools. The tools used in this research included a consent form (Appendix C), interview protocol (Appendix D), interview questions (Appendix E), and a demographic questionnaire (Appendix F) (Bamberg & Sandman 2013). Variance was reduced by using methods such as triangulation and cross-referencing. Triangulation and cross-referencing allow for the provision of effective targeted sampling (Glatthorn, Rouse and Joyner, 2013).

The interview protocol (Appendix D) was used to provide structure and consistency for the discussion. This interview protocol created clear explanations while probing into the stories that individuals told. In summary, it provided a script that helped guide the qualitative research through the interview process. According to McNamara (2009), an interview protocol helps ensure the same type of information is collected from all interviewees. The interview questions (Appendix E) were used to help understand the social phenomena in the natural setting with little disruption (Rubin & Rubin, 2012). Questions were broken down into centrally focused questions as well as probing questions. The central questions enlisted the interviewees to share their thoughts based on their lived experiences. The central question covered an overview of the communication issue. Probes were used to sort out information, based on credible evidence. This research used conversational management probes, which helped regulate

the level of depth and detail while keeping the topic focused, and adding further clarification (Rubin & Rubin, 2012).

The usage of demographic questionnaires helped capture the representation of all members of the population. For instance, an individual's age, sex, education, or ethnicity may influence certain responses. For example, someone who is 26 years old with a degree of experience may answer differently from someone who is 55 years old with a different level of experience. Demographics allowed analysis of sub-groups of respondents to the study. According to Business Research Lab (n.d.), this type of analysis can demonstrate how closely the sample replicates the known population. Moreover, it showed that the closer the distribution of demographic respondents matches the population, the more dependable the data. A brief analysis of the two home healthcare facilities involved in the study showed vast age ranges. Consequently, age ranges were represented in four categories: under 18, 18-35, 36-50 and over 50. The basic concept of qualitative research often draws from educational theories, constructs, sources, and models. The rationale for use of these instruments is constructed by practitioners and theorists such as Giles (1970); Rhodes (2013); Grant & Greene (2012); Murkofsky (2009) and Shaked & Schechter (2013).

Credibility

To ensure credibility, the same interview questions were asked of each participant, using the process of triangulation, for consistency (Patton, 1997). According to Patton (1997), triangulation is often used to check the consistency of findings that are generated through collection methods. Also, participants completed demographic questionnaires. The information collected from the demographic questionnaires helped to

determine both credibility and prudence, as well as represent a degree to which the population was characterized accurately.

This study accomplished credibility by using multiple perspectives to interpret the communication methodology and test for consistency. The goal was to ensure accurate representation of the population because the total population is not available. The sampling technique used established credibility by allowing for increased diversification in the study. Moreover, the coding process helped clarify description of concepts and generated themes. Coding helps maintain objectivity and increase the awareness of biases (Bryman & Bell, 2011, pp. 290). The coding procedures used for open-ended questions were developed by Bryman & Bell (2011). Those procedures provided a simplistic way of coding that alleviated the pitfalls of fragmentation of data, thus creating a narrative flow (Coffey & Atkinson, 1996). For instance, creating a coding schedule was a means of keeping a record of rules to be followed to identify precise answers, through the hand-coding process.

Concrete measures used to ensure credibility were member checking to confirm researcher interpretations of the participants' existence (Creswell, 2014). The demographic sheet (Appendix F) was used to verify each participant's existence. This sheet was used to check recorded characteristics, the member's suitability to provide his or her insight into the research topic. Credibility is established by discussing the issue in the same manner with multiple individuals from the organizations. Also used for the establishment of credibility was the clarification of researcher bias at the beginning of the study and throughout the study (Creswell, 2014). For example, research biases were

clarified by understanding the researcher's relationship, perspective, experience, and training regarding the subject.

Particular biases and assumptions showed the analysis employs specific thought sequences about the process of communication in medical facilities. For instance, management's lack of communication was due to their unwillingness to understand employees' needs. Second, communication was a skill that employees seldom rely on due to their lack of trust in management. Third, miscommunication was the primary facilitator for healthcare concerns. According to Creswell (2009), understanding personal assumptions and biases are crucial in research, to keep research credible and free of prejudice. In this study, the researcher's previous experience in healthcare led to stringent efforts not to interject personal opinions into the research. Self-awareness, constant reflection, and reliance on mitigation strategies are essential to keeping the researcher's own opinions out of the dissertation process (Creswell, 2009). For example, in this study, the researcher opined that managers handle training individuals in proper communication; however, if training is not given correctly, the organization will have quality and safety issues.

Trustworthiness

Measures used to ensure trustworthiness and consistency in this study included coding, member checking, and triangulation (Creswell, 2014). A valid outcome is provided for the study, demonstrating support and external evaluation of methods used. The research employed specific procedures to ensure nullification of biases throughout this study. An extensive review of the existing literature helped to eliminate researcher bias. An interview protocol instrument was used to outline the interview process.

Finally, questionnaires and statements were compared by using cross-checking procedures, allowing for efficient measurement (Creswell, 2014).

Data Collection

Semi-structured interviews were used to allow for a limited number of questions, as well as appropriate follow-up questions (Rubin & Rubin, 2012). The study used Excellence in Processing Open Cultural Heritage (EPOCHE) to ensure prejudices were not involved in the study. The primary component of data collection was the use of interviews for the collection of data, along with note taking. After the selection of participants was completed, participants were contacted by telephone to arrange interviews. The phone call was used to confirm the participant's interest and availability in participating in the study. After the participant confirmed his or her willingness to participate, a research introduction occurred. The research design consisted of semi-structured interviews, and criteria sampling to select participants and explore data collection. The sample was from participating home healthcare facilities. Each participant received an introductory letter describing the details of the research study, including methods of transcription for all interviews. At the beginning of the interview process, each participant signed an informed consent form in the presence of the interviewer after questions were addressed. At that time, each participant was informed that his or her participation was to be voluntary, and they could withdraw from the study at any time. A total of 25 personnel from various fields within the two organizations received an invitation to participate. Through pre-screening, all participants met the designated definition of the study.

The research design included a protocol to follow during the interview process (Appendix E). The protocol (Appendix D) was used to ensure that the study is productive. Using a semi-structured interview method ensured the study was consistent before, during, and at the conclusion of the interview process. According to Rubin & Rubin (2012), semi-structured interviews are qualitative in nature and are used to elicit views and opinions from participants. Because of the responsive interviewing style of the study, an interview script was used (Appendix D) (Rubin & Rubin, 2012). The interview script ensured all participants meet the requirements set by the research. This script also instituted consistent guidelines for the interview protocol by outlining the criteria for the study.

A demographic sheet (Appendix F) was formulated to collect specific information for the study. Demographic information included gender, race/ethnicity, education, employment status, and experience. According to Schuele & Marvin (n.d.), demographic information is needed to determine if individuals in the study are representative of the target population for generalization purposes.

Open-ended questions encouraged participants to discuss lived experiences regarding communication in home healthcare. Sub-questions were used to learn more details about participants' lived experiences. The questions allowed participants to discuss the devices that they would like to see used to enhance communication practices. The interview questions were helpful and relevant to defining the phenomenon and gaining understanding.

Data Analysis

All interviews, field notes, and observations were transcribed before data analysis was conducted. This process, which produced familiarity with the data (Reissmen, 1993), included creating Microsoft documents. The data from those documents, including interviews, field notes, and observations, were stored on secured computer devices through password protection. Peer reviewers assisted coding efforts by looking for meaning within the documents.

The peer reviewers' assistance enabled the recognition and assignment of codes and analysis of the results. Peer reviewers only had access to de-identified information. An audio recorder was uploaded to capture live interviews. The program provided an efficient means of storing and locating qualitative data. The data was protected because access was allowed only to a portable storage device. Data analysis included familiarization with the data and coded information, reading each transcript to immerse the data, and reviewing and defining a theme and creating a report.

The analysis of these organizations shows how communication affects a workgroup in a home healthcare facility. First, research and interview data were organized and analyzed. Next, the interviewer read and translated the data. Additionally, coding by two peer reviewers as a coding process generated a description of the data.

Phenomenological research revealed information about the phenomenon from individuals who have lived experiences (Moustakas, 1994). Qualitative researchers such as Rossman & Rallis (1998) used this process to understand participant behavior in an individual setting. The questions asked were broad in nature because research in this area was nascent. The meaning of the data was interpreted by using open coding. According to

Bryman & Bell (2011), open coding is the starting point for most forms of qualitative data analysis. This process used a method to reduce data while creating a mechanism for thinking about the implications of data (Bryman & Bell, 2011). Coding breaks down the data into constructs and occurrences. A matrix format was used to identify constructs along one axis, and events along the other axis (Bryman & Bell, 2011). Steps to coding were: (a) develop a system as the research progresses; (b) take notes to use for coding; (c) outline connections between concepts; and (d) interpret findings.

Bracketing

A researcher's bias is an important issue to consider in research (Creswell, 2010). Previous thoughts and experiences were taken into consideration at two stages: data collection and findings. Researcher reflection upon personal feelings and experiences must occur to recognize and suspend any potential biases. This process helped avoid biases that influenced the study. To ensure objectivity, experiences and opinions were set aside in favor of the use of data collected from field notes and participants' narratives. Any prior thoughts, preconceived notions, judgments, or prejudices were taken into consideration to ensure exploration of the study through questioning (Creswell, 2010). Also, although interviews were guided by a set of questions to explore communications in home healthcare facilities, supreme flexibility and openness were upheld. During data analysis, participants' statements were quoted without regard to their status or standing in the home healthcare field.

The following steps were followed to ensure that researcher bias did not influence the study: (a) Areas of interest were identified that could have been taken for granted and took into cautious consideration assumptions associated with ethnicity, race, stereotypes,

and socioeconomic status; (b) Participants' feelings were recognized as well as the researcher's opinions and experiences; (c) Participants had the opportunity to examine, corroborate, and verify study findings and voice their opinions on the authenticity of those findings; (d) Personal biases associated with preconceived notions of how managers communicate with subordinates were considered; (e) Personal bias associated with preconceived notions of how subordinates communicate with managers were considered; and (f) The provision of personal experiences with SBAR and QAPI were considered. In summary, this study described the phenomenon from the study participants' perspectives.

Ethical Considerations

Maintaining the confidentiality of data was primary in this research. The following processes are provided in this regard. Data was extracted from participant demographic questionnaires and interviews. Upon extraction, information was placed in a Word document that was delimited in a password protected computer. Accessible to the computer was restricted. The participants' responses to demographic questionnaires and the interview questions were kept separate from protected personal information, containing employment statistics. The questionnaires were created in Microsoft Word and were contained in a password protected computer. Accessible to the computer was restricted. Interview information was transcribed to Microsoft Word and contained in a password protected computer. Accessible to the computer was restricted. Confidentiality breaches were minimized by following procedures and policies outlined by the Health Insurance Portability and Accountability Act (HIPAA) and the Institution Review Board (IRB), regarding protected health information. The participants heard explanations of

HIPAA and IRB guidelines covering compliance issues and physical and data security to participants. This study, which does not relate to patients, addressed questions and concerns of subject participation.

Accessibility to records was restricted to the primary researcher, who performed the interview and questionnaire processes. The IRB of Colorado Technical University has access to the study information, as required. To provide safety, participants completed demographic data on an electronic form. Electronic forms were stored on a password-protected personal computer, and retained in a secure location. Data was obtained by the researcher only.

The potential risks to human subjects included stress, discomfort, invasion of privacy, and exposure of protected information, to employees, management, and the public. Minimization of risks was provided by following proper practices and policies as outlined by HIPAA and IRB Colorado Technical University regarding protected subjects in health information. Personnel involved in the study are the only ones allowed access to protected employee information. This information has been secured by restricting computer access.

The research ensured the participants' privacy, confidentiality, and anonymity in the interview session. The research informed participants that all subjects in the interview and demographic questionnaires provided are subject to confidentiality codes, as outlined by the IRB. Participants were told that information collected was used for study purposes only (Creswell, 2014). Additionally, participants were advised of their right to privacy and the safeguarding of their information through an informed consent form. Participants were informed about safeguarding of information through password protection and

document control. Collected information from participants was anonymous in terms of name, address, e-mail and phone number.

Summary of Chapter Three

This chapter provided an explanation of the research methodology. The element discussed in this chapter was a qualitative phenomenological design, which examines the lived experiences of participants in the home healthcare industry. This method presented the research with an exploratory approach, looking at themes and trends of the study, through participants' lived experiences. Other items specified are research questions, traditions, and research design, which are aligned with the purpose and problem of the research. The purpose of this study was to understand interdisciplinary communication between home healthcare managers and healthcare providers in a small facility. The population of this study covers 20 home healthcare agencies located in Arlington, Texas. Sampling procedures were used to identify and select participants that represented the community. The instrumentation provided for the study included semi-structured interviews, subject-completed demographic questionnaires, and note-taking to identify communication in the facilities. Instrumentation methods were devised in appendixes D through F and consisted of interview protocol, direct one-on-one interviews, and demographic information.

This chapter covered ethical considerations through systematic safeguarding and minimization of risk, provided by both the Colorado Technical University IRB and HIPAA regulations. Chapter Four provides the findings of this study. Chapter Four contains participant demographics while presenting data for a discussion of research results.

CHAPTER FOUR

The purpose of this qualitative phenomenological study was to explore the communicative experiences of home healthcare personnel. This chapter contains results of the data from the study as well as application to the central question. The interview protocol used six demographic questions and four open-ended questions. The central research question was: What are the lived experiences of home healthcare professionals regarding communication between managers and subordinates to facilitate patient care turnover? Two home healthcare organizations in the Dallas-Fort Worth Area were examined, and the experiences and perceptions of 16 home healthcare personnel were analyzed.

There were several challenges in conducting this study. The first challenge was obtaining letters of consent from facilities in the local area. Some managers felt that the research would not be beneficial to their organizations and created time restraints as a condition of participation in the study. Due to these time restraints, interviews had to be conducted during participants' availability.

During the interviews, study participants described their experiences and perceptions of communication in home healthcare. Data was collected from September to October of 2015. Chapter four is organized into six sections: (1) Participant Demographics, (2) Participant Profiles, (3) Presentation of Data (4) Interview Results, (5) Themes, and (6) Presentation and Discussion of Findings.

The goal of the research study was to understand the communication process through a review of home healthcare providers' and administrators' experiences. Research findings were reported based on analysis of the following data methods: semi-

structured interviews, open-ended questions and follow-up question for elaboration. Coding was used to decipher trends and themes of the data. The responses contained broad generalizations such as "communication is best provided by management providing a plan of care." The findings included that communication between managers and staff is typically provided through e-mail (K-mail, which is an inter-office intranet device), which is not always reliable. The problem with this device is that home aides may not check K-mail regularly. Consequently, this form of communication at times provided irrelevant and outdated information. Another primary method of communication was by telephone. Telephone calls worked fine in most incidents, but could be inconvenient during the process of care. A more in-depth overview of these findings is presented in this chapter.

Peer Reviewed Findings and Objectives Provided

The content of material was validated by utilizing subject matter experts with several years of experience in the home healthcare field. Peer reviewers were enlisted to help analyze the information and ensure all issues were covered. Assumptions and opinions were greatly reduced by emphasizing participant findings by using direct quotes from the participants. Two peers were asked to look for emerging themes in the data. After comparing the findings, the researcher and peer reviewers collaborated to determine the number of themes. Member checking was used to ensure validity, consistency, and proper interpretation of the findings (Rubin, & Rubin, 2012).

Participant Demographics

Participants in the study were administrators and non-management staff with one to ten years of home healthcare experience. Phenomenological studies rely on researching

participants who lived the experiences to understand the meaning of those experiences and to devise a relative understanding of the phenomenon under research (Moustakas, 1994). The study included residents of the Dallas/Fort Worth area concerned with the communication practices of home healthcare personnel. This study engaged 16 home healthcare participants with the intention of achieving adequate thematic inundation. The demographic profile included ten females ranging from 18 to 50 years old, and six males ranging from 36 to 50 years old. Thirteen of the participants were African American/Black, two were Hispanic/Latino, and one participant was Caucasian.

Educational Level

The 16 study participants' completed educational levels ranged from high school to graduate school. The vast majority of the participants, 80%, had some college or technical school training. The breakdown of participants' education level is two high school graduates, three participants with college or technical school experience, four with bachelor's degrees, and seven with master's degrees. For the protection of participants' privacy and confidentiality, names were not used in this study.

Table 1 shows the demographic profile of participants in the study.

Table 1

Demographic Profile of Research Participants

	Race/Ethnicity	Gender	Age	Educational Level
PI-1	African American/Black	Male	36-50	Graduate School (Advance Degree)
PI-2	African American/Black	Male	36-50	College 4 years (College Graduate)
PI-3	African American/Black	Male	Over 50	Graduate School (Advance Degree)
PI-4	African American/Black	Male	Over 50	Graduate School (Advance Degree)
PI-5	African American/Black	Female	36-50	Graduate School (Advance Degree)
PI-6	African American/Black	Female	36-50	College 1 – 3 years (Some college or technical school)
PI-7	Non-Hispanic White	Female	18-30	Grade 9 through 12 (High school)
PI-8	African American/Black	Male	Over 50	Graduate School (Advance Degree)
PI-9	African American/Black	Male	Over 50	College 4 years (College Graduate)
PI-10	Hispanic or Latino	Female	Over 50	College 4 years (College Graduate)
PI-11	African American/Black	Female	36-50	College 1 – 3 years (Some college or technical school)
PI-12	African American/Black	Female	36-50	Graduate School (Advance Degree)
PI-13	African American/Black	Female	36-50	College 4 years (College Graduate)
PI-14	Non-Hispanic White	Female	36-50	Graduate School (Advance Degree)
PI-15	African American/Black	Female	36-50	College 1 – 3 years (Some college or technical school)
PI-16	African American/Black	Female	Over 50	Grade 9 through 12 (High school)

Work Experience and Home Healthcare Position

The work experience of the16 study participants ranged from one through ten years. Over 60% of the participants had more than ten years of experience. Five of the study participants were administrators, two were clinical managers, and one participant was a Director of Nursing. Table 2 shows the demographic profile of participants' work experience and positions.

Table 2

Demographic Profile of Participant Work Experience and Position

	Home Healthcare Work Experience	Home Healthcare Position
PI-1	More than ten years	Manager/Administrator
PI-2	More than ten years	Manager/Administrator
PI-3	More than ten years	Non-Management/Nurse
PI-4	More than ten years	Non-Management/LVN
PI-5	5 years	Non-Management/Nurse
PI-6	1-5 years	Non-Management/CNA
PI-7	5 years	Non-Management/CNA
PI-8	5-10 years	Administrator/Clinical
PI-9	More than ten years	Administrator/CFO
PI-10	More than ten years	Director of Nursing
PI-11	5-10 years	Non-Management/Nurse
PI-12	5-10 years	Clinic Manager
PI-13	5-10 years	Clinic Manager
PI-14	More than ten years	Manager/Administrator
PI-15	More than ten years	Non-Management/CNA
PI-16	More than ten years	Non-Management/Nurse

Presentation of the Data

Data Collection Process

Each interview began with the presentation of the informed consent form and a reiteration of the purpose of the research. Participants received an informed consent form and asked if he or she would like to participate in the study. The data was collected by using face-to-face and telephone interviews with 16 home healthcare personnel.

A process called Excellence in Processing Open Cultural Heritage (EPOCHE) was used to prejudge notions in the process (Moustakas, 1994). Listening without preconceived notions allowed unbiased and clear understanding of the phenomena being researched (Moustakas, 1994). This method helped to minimize researcher biases and prejudgments during this process.

Telephone and face-to-face interviews were recorded using a Microsoft audio recorder. Notes were taken during interviews to ensure the accuracy of the data. Additionally, participants' responses were transcribed precisely to ensure accuracy.

The rationale for the interviews was to understand interdisciplinary communication in all home healthcare facilities. The central research question is: What are the lived experiences of home healthcare professionals regarding communication between managers and subordinates to facilitate patient care turnover? Coding and analysis were not started until after the 16 interviews were conducted, transcribed, and reviewed for accuracy to understand common themes. See Appendix F for a summary of each of the interviews.

Participant Profiles

In a semi-structured one-on-one interview, each participant discussed his or her communicative experiences in the home healthcare environment. The following overviews were compiled of participants one through sixteen.

Participant 1. The participant is a male between 36 and 50 years old, who is employed as an administrator/director of nursing. The participant has more than ten years of experience in healthcare and home healthcare. According to the participant, "the nurses receive details before they go into the field. This is done by communicating every detail and looking for feedback before nurses go into the field."

Participant 2. The participant is a male between 36 and 50 years old, who is employed as a manager/administrator in home healthcare. The participant has more than ten years of experience in home healthcare. He has been employed in the organization for more than a year. According to the participant, "the key to communication is proper documentation of patient needs. Proper communication can ensure that patient vital signs are adequate. These documents are then used to do an intervention if needed."

Participant 3. The participant is a male over 50 years old, who is employed as a non-management nurse in home healthcare. The participant has more than ten years of experience in home healthcare. He has been employed in the organization for more than a year. According to the participant, "the approach for communication between management and non-management is to review procedures before going into the field."

Participant 4. The participant is a male over 50 years old, who is employed as a vocational nurse in home healthcare. The participant has more than ten years of

experience in home healthcare. He has been employed in the organization for more than a year. According to the participant,

> Management communicates cases by using a method called a physician order form. This process provides the physician with what is needed regarding the health services of the patient. When updates are required, physicians use software called Credo MRS to communicate these measures.

Participant 5. The participant is a female between the ages of 36 and 50 years old, who is employed as a nurse. The participant has five years of experience in home healthcare. According to the participant, "…the manager…provides communication maintaining paperwork and diligently getting each member onboard with patient needs. An example of this is understanding the type of insurance a patient has, as well as what medications are required."

Participant 6. The participant is a female between the ages of 36 and 50 years old, who is employed as a certified nursing assistant (CNA) in a home healthcare environment. According to the participant, "communication is provided through one-on-one guidance on how to handle patient."

Participant 7. The participant is a female between the ages of 18 and 30 years old, who is employed as a CNA. The participant has five years of experience in home healthcare. According to the participant, "communication is the key to issuing out proper healthcare. For instance, relationships with management, clients, and physicians are essential to proper care. Specifically, communication is vital regarding client and physician introduction."

Participant 8. The participant is a male over 50 years old, who is employed as an administrator/clinician in home healthcare. The participant has between five and ten years of experience in home healthcare. According to the participant, "home healthcare has no formal communication methods. Communication is conducted through verbal, telephone, e-mail, and texts to provide proper assignment."

Participant 9. The participant is a male over 50 years old, who is employed as a chief financial officer (CFO) in home healthcare. According to the participant, "…communication between all parties via phone calls and meetings on a bi-weekly …[basis]…is vital."

Participant 10. The participant is a female over 50- years old, whose position title is Director of Nursing and Overnight Administrator. The participant has more than ten years of experience in home healthcare. According to the participant, "communication is conducted over the phone that provides a full report, using a sticker system."

Participant 11. The participant is a female between the ages of 36 and 50 years old, who is employed as a nurse. The participant has between five and ten years of experience in home healthcare. According to the participant, "communication is best done when a plan of care is provided for the clinicians beforehand."

Participant 12. The participant is a female between the ages of 36 and 50 years old, who is employed as a manager in home healthcare. The participant has between five and ten years of experience in home healthcare. According to the participant, "plan of care is a communicative method that allows management to provide a proper assessment of care. An overview of the patient care is a proponent of communication."

Participant 13. The participant is a female between the ages of 36 and 50 years old who is employed as a manager in home healthcare. The participant has between five and ten years of experience in home healthcare. The participant mentioned that "lack of communication often happens between the director of nursing and field staff (clinicians). Open dialogue is needed from the director of nursing to the providers for proper coordination of care."

Participant 14. The participant is a female between the ages of 36 and 50 years old who is employed as a manager/administrator in home health. The participant has more than ten years of experience in home health. According to the participant, "communication is sometimes shared with the nurse and the therapist. She explains that often certain disciplines are left out of the loop of communication."

Participant 15. The participant is a female between the ages of 36 and 50 years old who is employed as a CNA in home healthcare. The participant has more than ten years of experience in home healthcare. According to the participant, "using methods such as K-mail don't always allow for proper understanding."

Participant 16. The participant is a female over the age of 50 years who is employed as a nurse in home health. The participant mentioned that she is the oldest person who is employed as a nurse. The participant has more than ten years of home healthcare experience. According to the participant, "breakdown in communication happens when it goes through a third party without a formalized system."

Data Analysis

Coding allowed familiarity with the data (Reissmen, 1993), and content analysis was used to extract and organize transcribed data to identify codes that were relevant to

the study. Coding was used to identify the source of the data, extract credit from transcripts, and segregate the source and results for proper attribution. Coding was used to establish a categorization and aid further analysis. After the codes, categories, and themes were established, the information was analyzed and grouped based on similar themes.

The elements of the themes were clustered to form thematic groups. The listing and preliminary grouping code report generated five thematic labels: (a) Direct Verbal/Telephone Communication by Management; (b) In-Service Training; (c) Management not issuing a plan of care; (d) Compliance: by the Pill Box; and (e) Management issue plan of care before the process. These labels were critical to the central question.

Coder Findings

This section represents findings and themes developed through coding and verified by additional coders. Several points are explained with rationales by subject managers. Identification of the five major themes is provided in Table 3.

Table 3

Major Themes

	Subject Theme
Major Theme 1	Direct Verbal/Telephone Communication by Management to Subordinates
Major Theme 2	In-Service Training
Major Theme 3	Management is not issuing plan of care
Major Theme 4	Compliance: by Pillbox
Major Theme 5	Management issues Plan of Care before process

Theme 1: Direct Verbal/Telephone Communication by Management to Subordinates

This first thematic label was established from three elements (see

Table *4*). The elements central to the theme are as follows: (a) management communicate needs verbally; (b) management communicates needs by telephone; and (c) management communicates through e-mail/K-mail. K-mail is defined as an "inter-office communication device, similar to the e-mail process." These elements emerged from participants' responses to the question: What did he or she specifically do to communicate the needs of the patient and the assignment effectively?

The first element, management communicates needs verbally, emerged from responses from the 16 study participants. Participants stated that communication is provided primarily through verbal and telephone communication. Some participants shared that verbal communication is needed to compare and contrast management wishes and patient needs. Participant PI-14 said, "The nurse evaluates case management and patient medication every day. The tool we use in communication is a phone, e-mail or verbal communication." Participant PI-16 stated, "We communicate verbally to identify the medication and teach them the side effects of medication and drug interactions. It is an ongoing process that is communicated through assessment once a week."

The second element, management communicates needs by telephone, emerged from statements made by all16 study participants. According to their observations, communication is provided primarily through the telephone. They explained that telephone calls were key in communicating details from management to home healthcare aides. Most participants shared that they received a detailed assignment through this form of communication. Participant PI-2 explained, "The key is telephone calls are recorded on forms that tell what is going on with the patient." Participant PI-8 said,

"communication to staff is through verbal, telephone, e-mail and texts to provide proper assignment."

The third element is management communicates through e-mail and K-mail, emerged from statements made by five of the 16 study participants. These participants indicated that management used inter-office communication through K-mail, which provides a full description of care. Participant PI-10 said, "A complete description of care was given through K-mail services." Participant PI-15 said, "Typically, K-mail is widely used to communicate issues. Everything is done in this computer system, so we, as staff, communicate with that system."

Table 4

Major Theme 1: Direct Verbal/Telephone Communication by Management to Subordinates

Communication Theme to offer this experience	# of participants to offer this experience	% of participants
Management Communicate Needs Verbally	16	100%
Management Communicate Needs by Telephone	16	100%
Management Communicate through e-mail/K-mail	5	25%

Theme 2: In-Service Training

One primary element established the thematic label in-service training (see Table 5). The element central to the theme bi-weekly or monthly training. This element emerged from participants' responses to the question, how does your organization communicate new or existing processes to improve overall quality within the organization?

The element bi-weekly or monthly training emerged from responses from nine of the 16 study participants. They stated that training is conducted by assessing what worked and did not work in the field. After the assessment, management communicated the need for in-service training. Some participants shared that in-service was used mostly as refresher training, helping them to communicate needs to management appropriately.

Participant PI-2 shared, "In-service is performed every two weeks or pay day, to update the staff on what is current." Participant PI-4 said, "…Staff in-service…is given monthly or as needed. An example is when we did training in-service for Medicaid coding changes from International Statistical Classification of Diseases and Related Health Problems (ICD) ICD9 to ICD-10." Participant PI-11 said, "We do in-service every two or three months, also mandatory training every ten days to keep abreast of the changes."

Table 5

Major Theme 2: In-Service Training

Communication Theme to offer this experience	# of participants to offer this experience	% of participants
Bi-Weekly or Monthly Training	9	56%

Theme 3: Management is Not Issuing Plan of Care.

The thematic label is management not issuing of the plan of care was established by one primary element (see Table *6*). The element was a lack of communication between management and healthcare providers, having no plan of care, which emerged after nine of the 16 participants shared that typically a provider sees more than what was initially expressed by management. This element emerged from participants' responses to the question, please tell me about an opposite type of situation or scenario. In contrast, some participants shared that not having a plan of care communicated by management has been detrimental to patient care in the home healthcare industry. Participant PI-4 shared, "Sometimes when you visit the patient, you may see more than what is expressed,

you then have to go back and communicate with management." Participant PI-6 said, "At times, management does not explain to you the patient needs and how the patient behaves. Just calling makes it difficult, because you do not know where to start, and no initial training is provided on what is needed to be done." Participant PI-16 shared "There have been times I did not get the full report. Many times patients had a wound, and I did not know about it. The breakdown in communication sometimes happens because information is received through third party communication, rather than an initial plan of care."

Table 6

Major Theme 3: Management not issuing plan of care

Communication Theme to offer this experience	# of participants to offer this experience	% of participants
Lack of communication between management and healthcare provider, having no plan of care	9	56%

Theme 4: Compliance by Pillbox

The thematic label compliance by pillbox was established by two elements (see Table 7). The elements central to the theme are as follows: (a) evaluating patient compliance by pillbox and (b) quarterly audits. These elements emerged from participants' responses to the question, how does your organization communicate new or existing processes to improve overall quality within the organization?

The first element, evaluating patient compliance by pillbox, emerged from responses by four of the 16 study participants. They described that compliance was achieved through assessing what worked and did not work in the field. At that point, management communicated the need for training through in-service training. Some participants shared that in-service was used as mostly refresher training, helping them to communicate needs to management properly. Participant PI-10 shared, "Basically, we work on a weekly basis to make sure the patient is compliant, and every medication is being used, and nothing is missing. We give them a pillbox as a form of communicating medication and teach them how to use the pillbox, to ensure compliance to medication."

The second element, quarterly audits, emerged from four of the 16 study participants. Some participants shared that audits communicated compliance from management through home aide providers. Participant PI-13 said, "One of the requirements of having a home health license in Texas is…quarterly audits through a compliance and audit committee who receive services." Participant PI-5 said, "A by-product of the audit [is] …a quarterly Quality Assessment Process Improvement Report to see if expectations for each quarter have been met."

Table 7

Major Theme 4: Compliance by Pillbox

Communication Theme to offer this experience	# of participants to offer this experience	% of participants
Evaluating patient compliance by pillbox	4	25%
Quarterly Audits	4	25%

Theme 5: Management Issues Plan of Care before Process

One primary element established the thematic label management issues of plan care before the process (see Table 8). The element was the plan of care to healthcare providers, which emerged after four of the 16 participants shared that communication had been assessed through management by providing a detailed plan of care beforehand. This element emerged from participants' responses to the question, what did he or she specifically do to communicate the needs of the patient and the assignment effectively? Some participants shared that management communicated patient needs by providing a plan of care, which was essential to communicating patient care. Participant PI-11 shared, "The first thing the manager will do is give you (the provider) a plan of care (written doctor order). The plan of care is a full description of what is going on with the patient, what is needed, and the goal of care. It provides me with an excellent description of the assignment." Participant PI-2 said, "You have to a get a brief overview of the patient process. Management does this by issuing out a plan of care, which is verbal and or written."

Table 8

Major Theme 5: Management issues Plan of Care before Process

Communication Theme to offer this experience	# of participants to offer this experience	% of participants
Plan of care to healthcare providers	4	25%

Interview Results

Five major themes emerged from the data: direct verbal/telephone communication by management; management issues plan of care before the process; in-service training; compliance by pillbox; and management not issuing a plan of care. The study findings showed the use of various communication methods by both managers and subordinates in the home healthcare industry. Out of 16 home healthcare personnel, 9 stated, "communication ranges from basic phone call to in office K-mail (internet), meetings and processes, such as Quality Assessment Processing Improvement (QAPI), etc..." Managers also pointed out the use of communication and the necessity of proper communication depending on the situation in the industry. Communication is important when administrators provide care to home aides. Communication has been provided through process formulation and implementation avenues. A communication style that is seen as helpful is direct communication, which is not issued through third party personnel.

Presentation and Discussion of Findings

This study focused on common themes that emerged from participant interview responses to questions regarding communicative practices in home healthcare. The participants used several points or examples to elaborate on the managers' communication processes. The data shows that all labelers uncovered similar findings on communication methods.

Content analysis was used to extract and organize transcribed data to identify relevant codes in the study. The coding results established categorization and aided further analysis. After the codes, categories, and themes were established, the

information was analyzed and grouped based on similar themes. The information was also ranked based on the participants' highest and lowest responses.

The elements of the themes were clustered to form thematic groups. The researcher and peer reviewers generated five critical thematic labels, central to the research question: (a) direct verbal/telephone communication by management; (b) in-service training; (c) management not issuing plan of care; (d) compliance by pill box; and (e) management not issuing a plan of care. The following are specific coder findings on home healthcare managers' communication methods.

Subject PI-1 used more of a direct communication process— the top-down and bottom-up approach. "When I send the provider out to the field, he or she receives details on what he or she is expected to do."

Subject PI-2 said, "the key is telephone calls," which are recorded on forms that tell what is going on with the patient. Subject PI-2 continued,

> There is also documentation to communicate what is going on with the patient, for example, patient vital signs. Management can look at the documentation to see if intervention is needed. One of the primary sources of communication is the home aide calling the office when there is a change of condition. It is a means of communication because management oversees the documentation.

Subject PI-3 received communication directed from management primarily through communicating patients' needs:

> It is important for management to sit you down and tell you everything about the patient before you go out. Management explains it before they allow

you to go there. Specifically, management will review the procedures verbally and describe things by giving you the list of the things to describe.

Subject PI-4 uses communication directed from management primarily through a method explained as 4 to 5 physician order.

> Management does a good job in most cases every time. The format they use in communication is four to five physician orders that give the licensed vocational nurse (LVN) nearly everything that is needed. You have what you need to do for a patient and what the patient needs. The four to five [physician orders] show the diagram of the patient regarding the medication, even if you are not there.

Subject PI-5 uses communication directed by management primarily through the administration of paperwork, and explained,

> We have the order sent out to the doctor, and the nurse went ahead and did all the necessary assessment on the patient as well as the paperwork. Everything regarding documentation [and] record management was very diligent in getting everything by step as the order regarding the paperwork for the office, which was excellent with the field worker, the staff, and clerical apartment as well as getting all the proper documentation for the patient chart.

Subject PI-6 received communication directed by management primarily through the demonstrating of patient care:

> Management explains the medical part, including medication and patient sickness. When management is at the patient's house, they show you how to go about handling the patient, how to communicate with the patient when he or she is

agitated or refusing care. At times, [they] do a one-on-one demonstration of how to handle patients.

Subject PI-7 used communication directed from management primarily through allowing personal communication among management, subordinates, and clients.

> My most current patient… the way she got put into the program told me about her personality, disability needs, and things of that sort. Had an excellent personal communication with the patient/client and related that personal relationship with myself in giving me the assignment. Great communication between myself and the client is very important.

Subject PI-8 received communication directed from management primarily through telephone and e-mail communication. The subject said, "As the administrator responsible for the clinical assignment of the office, the LVN, and aides. Specifically, it is communicated through verbal, telephone, e-mail and test to provide proper assignment."

Subject PI-9 stated that, at times, management, must provide direct communication, as well as top down and bottom up communication.

> I work on the weekend. Sometimes we were short of staff, so my job is to reshuffle and reassign employees and provide maximum patient care. We communicate those issues by calling individuals and reshuffling staff. As a nurse, sometimes I must get involved and take off my chief financial officer (CFO) [hat] and fill that position. The manager at times has to get on the floor and give the same care "hands-on communication. This is done until they relieve me, and I go back to my manager position. We practice direct communication for everybody.

Subject PI-10 received communication directed from management primarily through electronic measures such as K-mail (the interoffice internet) as well as follow-up calls. Subject PI-10 stated,

> Often, communication is done through notifying the nurse by K-mail (used on a secure website). A full description of care was given through K-mail service and a follow-up phone call for wound care and how to communicate with the family.

Subject PI-11 received communication from management primarily through a verbal or written plan of care:

> The first action a manager takes gives you a plan of care (written doctor order), which is a full description of what is going on with the patient, what is needed, and what the patient's need is, because everyone is different in home healthcare. The physician will tell you what the patient's needs are, and how to treat them.

Subject PI-12 received communication from management primarily through verbal and written plans of care:

> Before you take on medication, you have to have a brief overview of the patient process. Management does this by issuing out a plan of care which is verbal and written. Specifically, go out and assess the patient and from their assessment do a plan of care. Then from the plan of care access an order to take care of the patient.

Subject PI-13 received communication from management primarily through telephone interaction, which is direct communication:

The physician often provides communication. He or she gives demographic and detailed information including the pharmacy, background, company, and primary provider information, including the shot kit that needs to be in the patient's home. This is communicated by the physician by giving the hospital discharge paper. The physician gives all the necessary tools needed, including the patient information to be able to take care of that patient.

Subject PI-14 received communication from management primarily through telephone interaction, e-mail, and direct communication:

Communication is performed through electronic mail; we also have an interdisciplinary conference once a week for all staff. We usually talk about the diagnosis, and what type of disciplines patient need in the home, verbally or via e-mail to the staff.

Subject PI-15 received communication directed from management primarily through telephone interaction, which is direct communication:

My supervisor calls me a couple of days before, which is helpful in setting up an appointment time. She gives me all the relevant information. It is better to receive a phone call than a text. By doing this, I received all the necessary information immediately. Specifically, communication is done via phone call.

Subject PI-16 received communication directed from management primarily through telephone interaction, which is direct communication:

In general, the manager gives a good report on diet and mobility of the patient. Communication is done via phone or face to face. Managers tell me about the patient, whom the patient lives with or if they live alone. Also, how

well they perform, what can they do for themselves as well as their needs, well-being, and general living accommodations. Moreover, medication compliance and who prepares the medication.

Themes

Coding was used to detect five major themes and eight minor themes. The first major theme received 16 of 16 responses in the sample population in the study, or 100% from two of three categories. The second theme received nine of 16 responses of the sample population in the study, or 56%. The third issue received nine of 16 responses of the sample population in the study, or approximately 56%. The fourth theme received four of 16 responses of the sample population in the study, or 25%. The fifth theme received four of 16 responses of the sample population in the study, or 25%.

Summary of Chapter Four

The purpose of this phenomenological study was to understand interdisciplinary communication between care home managers and healthcare providers in a small facility. Specifically, it looked at home healthcare facilities while determining proper communicative methods for these facilities. The lived experiences and perceptions of sixteen participants were essential in understanding the home healthcare communication process. Chapter Four included a review of the data collection process, demographics of the participants, emerging themes, and presentation of findings. The interview was conducted, transcribed, and analyzed through coding. Through transcription of interviews, coding identified five major themes, which emerged from the perceived positive or negative communicating processes of management. Sixteen transcripts, documents, and field notes were collected and coded to help answer the central research

question. The study examined how managers in home healthcare communicate methods to subordinates. The five themes found were all valid and reliable in addressing the central question of the study. The major themes answered the question of how managers and subordinates communicate.

Chapter Five contains further implications of the findings as they relate to the central research question. Chapter Five restates the purpose of the study, summarizes the findings, the conclusion of the results, limitations and implementation to practice, possible future research, and recommendations for further studies.

CHAPTER FIVE

The purpose of the study was to explore the lived experiences of home healthcare managers and subordinates in the home healthcare industry. The study attempted to answer the question, what are the lived experiences of home healthcare professionals regarding communication between managers and subordinates to facilitate patient care turnover? The first section will address findings and conclusions of the study. The next section will include the limitations of this research, followed by sections on implications and recommendations for future research as a result of this study. The last section is a summary of this chapter.

The study was based on gaps in current and recent research in healthcare communication. Specifically, this study addressed the general communication gaps between employees in home healthcare and healthcare. As an exploratory study, it contributed to the concept of communication in home healthcare by addressing communication needs. These gaps were addressed by conducting exploration into home healthcare organizations. Experienced managers were interviewed to explore communication deficiency methods in home healthcare. The study started with a literature review on communication methods in healthcare organizations. The literature review provided a better understanding of the problem, theories, concepts, and significance of the study. The literature review also provided a better understanding of the use of Quality Assessment and Performance Improvement (QAPI) and Situation Background Assessment Recommendation (SBAR). The use of QAPI and SBAR have been helpful in standardizing communication in many organizations, including healthcare

(CMS.gov, 2013). This study demonstrated how home healthcare can improve healthcare safety and quality through better communication methods.

Through the use of semi-structured interviews, multiple perspectives of data were introduced by participants, which allowed inductive analysis. This analysis was helpful in understanding the major communication themes. Creation of a holistic perspective was established by using the theoretical lens, emergent designs, and interpretive inquiries (Creswell, 2009).

Relevant Theories

The literature review examined Human Relations Approach, Communications Relations Theory and Systems Theory to understand the communication process and to provide communicative measures. The Human Relations Approach provided an understanding of people's desire to be part of a supportive team that facilitates both growth and development. Therefore, employees would be encouraged to participate in the communication process, motivating them to be more productive, resulting in a higher quality of work. The findings showed that Systems Theory emphasizes communication as a means for members of the organization to work together effectively. In home healthcare, this means establishing strong communication among the manager, subordinate, and clients. In turn, these relationships maintain the balance and increase home healthcare productive. Communications Relations Theory is also helpful in understanding how to overcome barriers to communication. These barriers are addressed through the seven Cs of Communication: clarity, credibility, content, context, continuity, capability, and channels.

Findings and Conclusions

This research addressed the lack of communication between management and subordinates, which affects decision making. The study transpired in the Dallas/Fort Worth Metroplex, specifically in Arlington and Dallas, Texas. This study used a qualitative phenomenology methodology (Moustakas, 1994; Creswell, 2009). This method is normally used when the subject is exploratory. The study resulted in five emerging themes highlighting communication practices and actions managers take in the home healthcare industry: direct verbal/telephone communication by management to subordinates; in- service training: compliance by pillbox; management issues plan of care before process; and management not issuing a plan of care. Data collected from 16 participants created an understanding of the communication relationships between managers and subordinates. The research was facilitated through semi-structured face-to-face and phone interviews. The findings also addressed the following three theories: Human Relations Approach, Communications Relations Theory, and Systems Theory.

Coding was used to identify consistent themes. Two independent reviewers performed qualitative data coding and provided study validity through member checking. The two selected reviewers evaluated all documents, notes, and transcripts and presented coding themes. The independent reviewers read all interview transcripts, documents, and field notes. The most insightful findings included the implications of the plan of care. Twenty-five percent of respondents cited the lack of a plan of care had negatively influenced employee communication and patient care. The major themes follow.

Major Theme 1

Direct verbal and telephone communication by managers in home healthcare involves verbal, telephone, and e-mail/K-mail communications. One hundred percent of the participants perceived that direct verbal/telephone communications are used primarily to share information from management to subordinates. This major theme was supported by member crosschecking.

Major Theme 2

Effective communication in home healthcare involves in-service training. Fifty-six percent of the participants perceived that in-service training is the key to communicating training and information to management and subordinates.

Major Theme 3

A process of communicating compliance of medication was conducted through proper pillbox maintenance.

Major Theme 4

Successful communication often means management issues a plan of care before the process**.** Twenty-five percent of the participants perceived that successful management issues plan of care to communicate to subordinates needs and care beforehand.

Major Theme 5

The final aspect of the findings is management lack of issuing a plan of care. Fifty-six percent of the participants stated that communication was significantly affected

by management's failure to provide a plan of care. This plan of care acted as a communicative method between management and subordinates, providing the same thought process of care.

Major Themes' Relevance to Study Propositions

Proposition one recommended that communication methods can be used to help promote better communicative practices in home healthcare facilities. The research showed that there were communication methods that were successful and some that were not. For instance, theme one supported the proposition by showing that one hundred percent of participants used verbal and telephone communication to ensure information was communicated effectively. Theme two also supported the proposition, showing that using communicative methods such as in-service provided proper training for 56% of the participants. Theme three supported the proposition by explaining that using a pillbox as a method enhanced medication compliance. Themes four and five showed the importance of a plan of care. These two themes supported the proposition by showing why a plan of care must be communicated properly. A plan of care ensures efficient communication and patient safety. Participant 16 stated that "Communication is not all inclusive, and we have to come up with a plan of care for what the patient needs."

Also, the research found some of the initial elements described. For example, the research found that managers and subordinates were more effective when relating face-to-face or by telephone. The study found that methods such as e-mail or K-mail were ineffective because the information was not fully shared. For instance, participant 13 stated: "Text messages and K-mail are not helpful because… [they are] …not received right away." The outcome of this finding was that the patient was not receiving the

proper care. Unfortunately, this deficiency provided a disconnect between management's and subordinates' perspectives. Participant 16 stated: "There have been times I did not get the full report…i.e. not knowing the extent of a patient's wound." The themes supported the initial proposition by initiating better communication methods, reducing medical errors, and providing better treatment.

Proposition two recommended that managers could communicate issues better through the use of QAPI and SBAR. Although the study produced limited information regarding the use of QAPI and SBAR, it established the need for using QAPI and SBAR, or tools like QAPI and SBAR. Theme one showed home healthcare personnel utilize limited communication methods. These methods were not always reliable, resulting in miscommunication, which often leads to errors, thus, a level of standardization is required in home healthcare. Calling was shown as a viable method for some providers while others believed a more standard process of communication was needed. For example, participant six stated:

> Just calling makes it difficult, because you do not know where to start, and no initial training is provided on what is needed to be done. Because of this, you do not have proper communication, and you find that you do not have what you need. Theme two supported the proposition by indicating that communication through methods such as in-service provides updated information.

Participant four stated: "A by-product of facility audits is through QAPI reports." These reports were used to see if expectations for each quarter had been met. QAPI is used for chart reviews, and could be extended in medication compliance and establishing a plan of care.

The study explored the use of QAPI and SBAR to provide better communication in home healthcare. The general feedback from the study indicated participants' familiarity with SBAR. The study shows that the QAPI process was used by only one of the 16 study participants. SBAR was not used by participants in the study. Therefore, it was not evident in home healthcare. Because of the limited information provided on SBAR and QAPI, more specific and comprehensive information is needed. Elements in the findings showed that the use of QAPI in the quarterly report and chart reviews could improve communication. The major issue in participant complaints was miscommunication of inpatient reviews. For instance, one participant stated that "using QAPI addresses how physicians and administrators consult over patient medication." The findings show that both QAPI and SBAR could have a positive impact on communication in home healthcare, providing clarity and feedback. QAPI could help managers and subordinates focus on particular problems and complaints. According to CMS.gov (2015), QAPI can provide efficient communication by gathering information, allowing for process clarification. SBAR permits managers to organize and present information, enabling managers to communicate changes in patient status. According to Cunningham et al. (2012), SBAR can increase overall operations, creating an environment for teamwork and effective processes. Other implications for practice from this study included creating a plan of care. A plan of care could stabilize communication between managers and subordinates. For example, participant 16 stated, "there have been times that I did not receive the proper report due to no plan of care." In addition, in-service training is valuable in communicating the needs of manager and subordinate

training. For instance, participant two stated, "In-service training is performed every two weeks to update the staff on what is current."

There is a lack of reference to QAPI and SBAR in the findings due to the infrequent usage of these methods in home healthcare. One participant stated: "QAPI is used in my facility to produce quarterly audits." There are many elements of QAPI missing in home healthcare, such as proper feedback, systematic analysis of procedure, and structured approaches. The findings would suggest that using QAPI could help facilities develop policies and procedures that lead to healthcare proficiency. Specifically, the use of QAPI could provide patient safety and satisfaction. Moreover, it would provide home healthcare the ability to identify, monitor, and prevent medical errors in patients. According to CMS.gov (2015), QAPI can help improve the quality of life, care, and services in nursing homes. It can also identify opportunities for improvement, address gaps in systems or processes, and implement improvements or corrective plans (CMS.gov, 2015). This process of communication is imperative to the effectiveness of home healthcare improvement.

SBAR is a method that was not found in the study data. These elements would improve communication and address complaints due to miscommunication. According to Leonard (2004), elements include getting a person's attention, expressing concern, stating the problem, proposing action, and reaching a conclusion. Implementing these elements allows managers to focus better on the elements of communication, such as problems or concerns (Leonard, et al., 2004).

The major participant complaint was miscommunication of inpatient review. For instance, one participant stated, "using QAPI addresses how physicians and

administrators consult over patient medication." The findings implicate that both QAPI and SBAR could have a positive impact on communication in home healthcare, providing clarity and feedback. QAPI could help managers and subordinates focus on particular problems and complaints. According to CMS.gov (2015), QAPI can provide efficient communication by gathering information and allowing for process clarification. SBAR would allow managers to organize and present information, allowing managers to communicate changes in patient status. As stated, QAPI is a process that measures quality by communicating the situation and background of the issue. SBAR could be used to assess the situation and background of the issue, providing a recommendation for improved comunication.

Limitations of the Study

There were eight limitations in conducting this study. The first limitation was overcoming researcher biases due to previous experiences. This limitation is important because biases often translate personal beliefs into the study. These personal beliefs can skew the data and help determine outcomes. According to Scheurich (1994), a person's historical position, class, race, gender, and religion can interact and influence, limit and constrain the production of knowledge. To a large extent, personal biases determine what is to be studied. The limitation's impact on a study includes not seeing important information, which can impact the quality of the research. The quality of the research is heavily dependent upon personal biases and idiosyncrasies. This limitation could not be avoided due to the researcher's presence during the data-gathering process.

Second, the study was limited to the participation of home healthcare facilities. For instance, small facilities provide a limited number of employees to evaluate the home

healthcare process. This limitation is important because limited participation often impacts saturation of the study. It is vital to achieving saturation to ensure the quality of the data. Moreover, participation satisfies the perceptions and insights of a group of individuals. According to Creswell (2009), qualitative samples must be big enough to assure that all the perceptions that might be important are covered. Limited numbers in this study could not be avoided due to lack of participation by facilities. Several facilities would not participate due to privacy and confidentiality issues.

Third, the research was limited to the amount of data collected due to employee involvement. This limitation is important because the amount of data collected impacts the study findings directly. This limitation could not have been avoided during the data collection phase of the study because the interviews varied in length and at times were shorter than expected. In retrospect, it was concluded that having a combination of open-ended and concrete questions would have resulted in a richer set of data.

A fourth limitation was participant availability. The availability of participants affected the sample size; some participants were not available. A larger sample size may have produced more in-depth data. This limitation was a present because several organizations decided not provide employees and declined the opportunity to participant in interviews. Consequently, the study has limitations regarding employee information and data.

Fifth, the research had no valid tool, which culminated in the development of a new tool for analysis. This is important because qualitative researchers aim to gather an in-depth understanding of human behavior. The research tools developed impacted the findings about the human behaviors. These limitations also impacted the why and how of

decision making, creating more focused samples. Because it is a nascent study, relatively new to the home healthcare industry, these limitations could not be avoided.

Sixth, the interview protocol did not contain questions specifically related to the communication practices conveyed by the study. Creating better prompts and probes would be more effective in keeping the interviews on track. This limitation is important because prompts allow unexpected data to emerge, allowing for adjustment in the design of the study. This limitation impacted how interviewees responded to main questions. For example, asking background questions can provide a better understanding of the participants' lived experiences. A better understanding is important because it allows for participant perspectives. The impact of this limitation is seen in the communication structure between manager and subordinate. These limitations could be avoided by implementing more prompts and probes in the questioning process.

Seventh, with a small study, the criteria resulted in participants from the Dallas and Fort Worth, Texas area, limiting the generalizability of the study's findings. Qualitative studies often require a larger sample size to ensure accurate representation of the population. According to Miles & Huberman (1994), small sample sizes may not adequately support claims of having achieved valid conclusions. This limitation is important because larger studies often achieve more validity through better interpretation. For instance, small studies can give false-positive results, producing over-estimation in the magnitude of the study. However, this limitation could not be avoided due to the available sample.

Eighth, the participant sampling technique resulted in the majority of participants being African American. The resulting data featured information primarily from two

ethnic groups, African American and Hispanics. While there was no intent to limit the analysis to a particular group of participants, the research mostly revealed this stratum of certain populations, which could influence the data. This is important because more diversification allows for perspectives from other ethnic groups, resulting in diversified data. Also, the impact of this limitation is seen in the results of the study. This limitation could not be avoided due to the representation of the population in the area.

Implications for Practice

The findings of this qualitative study can be used to develop and improve upon communication methods in home healthcare. The improvement could be seen in the relationship between managers and subordinate employees in the workplace. The study can be used as a basis to improve overall communication in home healthcare, leading to more efficient and effective care of patients. Second, the implications of the study can be used to focus on processes to improve productivity via communication. Analysis of the study data found that communication methods can be used to help promote better communicative practices in home healthcare facilities. It is also suggested that managers can enhance communication through methods such as QAPI and SBAR.

An interview protocol that utilizes a pre-determined set of questions based upon these propositions was employed to ask every participant primary and secondary questions about home healthcare communicative practices. The results of the study are important in the implications of home healthcare industries. The study of communication methods is a relatively new study for home healthcare. The results of this study provided five conclusive themes. These themes are relevant to communication management practices regarding subordinate development and proper care. Specifically,

these themes are relevant in how managers view communication, and what methods are helpful and which are not. For instance, e-mail and text messages are not as effective as a phone call and one-on–one communication. For home healthcare industries to be effective, serious attention needs to be applied to communication. It is concluded that communication is important in the manager and subordinate roles. To be successful, managers and subordinates have to be willing to create communication opportunities.

The results of this study can help home healthcare facilities standardize methods of communication. For instance, the use of methods such as QAPI and SBAR can provide clarity to patient practices. QAPI and SBAR will help managers increase accuracy and safety in patient care, nullifying mistakes. Mistakes often happen in healthcare due to miscommunication, leading to improper care as well as the lack of compliance. Use of SBAR and QAPI could change a clinician's job by adding communication efficiency to processes. For example, using SBAR at the beginning of a shift can get each member on the same page, and avoid confusion later. Using these methods in home healthcare can provide shared communications with clinicians, physicians, and managers.

The study is important in the implications for home healthcare managers and subordinates regarding shared communication and effective teamwork. Shared communication means creating effective teams. Effective teams inspire trust, collaboration, and respect among employees. According to Rosenstein and O'Daniel (2014), tools such as SBAR can be "used to create mechanisms for establishing conversations, especially critical ones that require a clinician's immediate attention and action." This recommendation represents an easy and focused way to set expectations for

members of the team; it communicates an essential information transfer for cohesive teamwork. Not only is there familiarity in how people communicate, but SBAR will also develop desired critical-thinking skills in home healthcare. The person initiating the communication knows that before he or she picks up the telephone, he or she needs to provide an assessment of the problem and offer potentially appropriate solutions.

In a complex environment such as healthcare, managers often struggle to work with subordinates. The consensus from managers is that subordinates do not pay attention to verbal communication. This issue can be eliminated by implementng the group dynamic of reaching a consensus on daily decisions. Moreover, communication from all staff can establish operating policies and procedures at each level of success.

Implications for this practice show that email and texting are not effective methods of communication. Face-to-face and phone calls work better, but these methods still are not efficient tools for practice. It is important that all data be handed off uniformly and completely. Therefore, a method such as SBAR can provide a template for communication. Additionally, QAPI can be used to look for facility progress.

Implications of Study and Recommendations for Future Research

The study findings support existing theories of communication while raising questions for further exploration into communication in home healthcare. The findings also provide an argument for further investigation into the use of tools, such as QAPI and SBAR, to improve communication in home healthcare. Using these methodologies may initiate better communication. For example, SBAR may be used to create an environment of understanding. This environment can lead to understanding patients better, regarding situations, background, assessment, and recommendation. Shared expectations between

patient and staff and between staff members may be created. According to Fleming (2013), SBAR promotes communication by presenting a formula that illustrates situations sharing background information and joint assessment of the issue. The use of QAPI can potentially provide home healthcare with organized data feedback. If implemented, it may be used to communicate safety, accountability, fairness, and openness. According to CMS.gov (2015), implementing QAPI in healthcare can provide a systematic, comprehensive, data-driven, and proactive approach to performance management.

Additional research is recommended to expand the scope of this study. A potential area for future research could include using the same questioning in larger home healthcare facilities. Similar findings would be considered in other parts of this country, which may or may not align with these findings. Another recommendation would be to implement QAPI and SBAR to see if these methods would solve problems. Moreover, research should include studies on communication and management roles as they relate to future implementations. Other research would include communication practices among physicians, home aides, and management. This research would help understand the disconnect caused by third-party communication. The following are recommended to verify the findings of this research:

The study should include medium and large home healthcare facilities, which may provide indepth data. The study of managers within a certain age range or years of experience may provide more specific data. More specific data will provide better understanding of home healthcare managers' lived experiences. Conducting focus groups regarding the initial findings could improve the stability and consistency of the findings. By doing this, reduction of potential researcher bias can lead to a better

interpretation of data. This is important because the study cannot in any way favor a preconceived stance. A preconceived stance institutes unreliable questions thus skewing the data and information. Second, a pilot study is recommended to be used to create more in-depth interview questions. Using a pilot study helps develop more reliable and valid questions. According to Leon (2010), a pilot study can provide good clinical practices, including refinement of source documentation, informed consent procedures, data collection tools, regulatory reporting procedures, and oversight procedures. Third, it is recommended that more effective and efficient instruments are developed to conduct face-to-face interviews. Face-to-face interviews more precisely prescribe the concerns of managers and subordinates. Fourth, qualitative and quantitative methodology studies are recommended, to find out what approaches are most effective to help staff better create communicative methods. Fifth, it is recommended that research be expanded beyond the Dallas/Fort Worth metropolis, creating more accurate representation and assessment of the population. Lastly, expand the research boundaries to include a wider range of ethnic participation, allowing for more diversity and reliability of the study. Expanded research boundaries would provide a greater comparative understanding of communication. For instance, comparative understanding can nullify incorrect assumptions about communication shown in two primary ethnic populations. Also, more participation from a larger sampling of ethnic groups can improve communication strategies and better inform future communication methods.

It is evident that managers and subordinates differ in their conclusions about the reasons communication is ineffective. According to a participant who is in a management role, managers believed "communication would be more successful if home

aides listened better to instructions." One participant who works in a subordinate role stated, "Managers do not always communicate the big picture, and do not fully explain the patient's needs and behaviors." If perceptions remain different, a breakdown in communication will occur about the plan of care, medication compliance, and overall quality of care.

This study recommends looking further into the use of QAPI and SBAR to address and correct these issues. Managers can create an environment that establishes safety and quality through fluent communication. Lastly, the study recommends looking at how an efficient plan of care may lead to effective communication throughout home healthcare facilities. This is relevant regarding patient, subordinate and manager connections. These connections are viable to the attributes of teamwork, problem solving and effective decision making. These attributes could, in turn, decrease deficiencies that lead to patient harm in home healthcare.

Reflections

The ability to communicate is a vital ingredient in creating better healthcare. Each healthcare professional has the responsibility to model his or her conduct and performance through progressive communication. The healthcare environment is a huge platform that requires all professionals to be in concurrence to divert unfortunate circumstances.

Managers must create a level of communication that is conducive to success and patient care. The study was viewed by home healthcare professions as worthwhile and will add to the existing body of literature. It is believed that this information will help home healthcare personnel with the development of communicative standards.

Participants shared beliefs that better communicative methods could establish better care. It is suggested that further research is needed to develop communication methodology in the healthcare industry. This research is needed especially because safety and error prevention reveal ineffective and insufficient communication between managers and team members, contributing to adverse care. Moreover, miscommunication has been driven by the complexity and unpredictability of professionals in this unique and challenging environment.

In retrospect, the study should have included questions that would have allowed participants to speak about the differences and similarities of communication styles they experienced. This would have been appropriate since one of the criteria for the study was to understand the participants' lived experiences and thoughts about communication process between management and subordinates. Future studies should include a pilot study, which will be helpful in developing more deductive research questions. More particular questions related to the individuals could produce more deductive information.

The research also created unforeseen happenings. First, it was expected that the majority of participants would be male. Instead, females proved to be the majority. Second, managers were expected to share more of their policies on communication. However, the study found that home aide personnel and the staff was more forthcoming in that regard. Lastly, it was interesting to see that, based on their responses, many participants were open and willing in their comments to improve the management–subordinate communicative relationship.

Conclusion

Communication is the most important element for effective management in healthcare. The goal of this qualitative phenomenological research was to understand interdisciplinary communication between home healthcare managers and healthcare providers in a small facility. Analysis of the emerging themes showed that there are deficiencies in communication between management and subordinates. The results of the study can potentially help home healthcare managers to be better communicators in their industry by identifying areas of weakness. Managers can be better at communication through establishing better processes, such as QAPI and SBAR. Managers also can perform better in setting concrete goals within their plans of care. Furthermore, managers can use better communication methods, instead of texting and e-mail, which were proven to be inadequate. Face-to-face, proper document turnover, and even phone calls are better methods for communication. The study shows that managers can receive results by enlisting feedback and establishing clarity of treatment.

This phenomenological study was conducted to fill a gap in the literature by investigating communication among home healthcare professionals. This study recorded the actions and intent of a sampling of participants in Dallas, Fort Worth, Texas. As evidenced by the findings of this study, some of the previously discussed findings were corroborated. For instance, home healthcare teams experienced breakdowns in communication that produced misinterpretation of instructions that resulted in medical errors.

The research design was qualitative, using exploratory analysis to establish and indicate the issues of communication. The research also emphasized a phenomenological

view in which reality inheres in the perceptions of communication through individuals. The research relied on the theoretical concepts of the Human Relations Approach, Communications Relations Theory, and Systems Theory. These theories emphasize the importance of human communication, in both work and social settings, in creating a collaborative effort, which is helpful in guiding basic communication and decision making (Seitz et al. 2011, Herzberg 1959 and Cyert & March 1963).

The study results show deficiencies that may be addressed by implementing tools or processes such as QAPI and SBAR. This study evaluated communication processes and practices and identified strengths and opportunities. As seen in this study, participants have used these processes to establish reports that communicate employee training and patient care. The study included five themes developed inductively from two home healthcare facilities in the Dallas/Fort Worth metropolis: direct verbal/telephone communication by management to subordinates, in-service training, compliance by pillbox, management issues plan of care before process, and management not issuing a plan of care. This study may contribute to home healthcare by providing a better understanding of home healthcare communication experienced by management and subordinates. This study may benefit the organization by providing methods to enhance communication processes.

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APPENDIX A: LETTER OF PERMISSION

CORDIAL CARE HOME HEALTH SERVICES, INC.
HEALTH FIRST

Letter of Permission

May 11, 2015

From: Carl Burgess, Colorado Technical University
204 Forest Ridge Drive
Mansfield, TX 76063

To whom it may concern:

I am a Doctoral student at Colorado Technical University, and would like for permission, to include your organization in my study. The dissertation will be made available to the public, through Colorado Technical University online, PROQUEST. Questionnaires and interviews approximately 15 minutes will be administered to selected employees All information is safeguarded and participation in this study is voluntary.

I very much look forward to speaking with you and thank you in advance for your assistance in this project. If further information is required, please contact me at carl.burgess10@student.ctuonline.edu. Additionally, you can contact the chair of my study, Dr. Alexis Schmitt, alschmitt@faculty.ctuonline.edu, 412-953-8408.

If these arrangements meet with your approval, please sign this letter, on letter head where indicated below and return it to me per our initial meeting.

Thank You.

Carl Burgess, MHA, MHRM

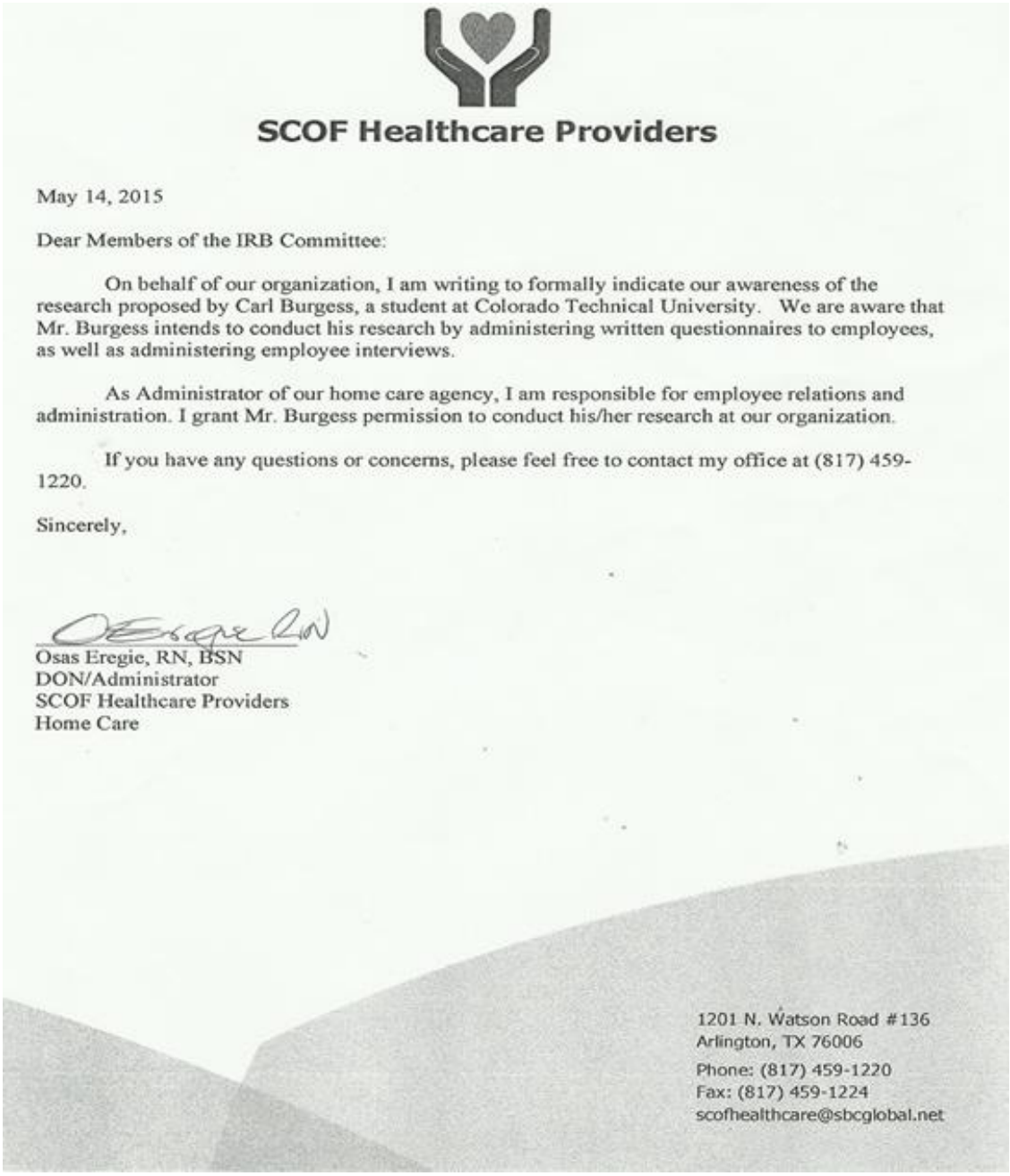
PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

Signature

Date: 6/22/15

661 ROSEMARY DR. ROYSE CITY, TX. 75189.
TEL: 972-603-6676. FAX: 469-722-3136 EMAIL: cordialcare1@yahoo.com

APPENDIX B: LETTER OF PERMISSION



SCOF Healthcare Providers

May 14, 2015

Dear Members of the IRB Committee:

On behalf of our organization, I am writing to formally indicate our awareness of the research proposed by Carl Burgess, a student at Colorado Technical University. We are aware that Mr. Burgess intends to conduct his research by administering written questionnaires to employees, as well as administering employee interviews.

As Administrator of our home care agency, I am responsible for employee relations and administration. I grant Mr. Burgess permission to conduct his/her research at our organization.

If you have any questions or concerns, please feel free to contact my office at (817) 459-1220.

Sincerely,

Osas Eregie, RN, BSN
DON/Administrator
SCOF Healthcare Providers
Home Care

1201 N. Watson Road #136
Arlington, TX 76006
Phone: (817) 459-1220
Fax: (817) 459-1224
scofhealthcare@sbcglobal.net

APPENDIX C: INFORMED CONSENT

Title of Study: Communication Methods: A Qualitative Study On Communication Methods in Home Healthcare Facilities

Investigator: Carl Burgess

Contact Number: 682-351-4527

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is to explore the lived experience of home healthcare personnel in regards to communication.

Participants

You are being asked to participate in the study to provide insight into communication processes in home healthcare. Your opinions, outlook, and ideas with respect to the research questions are critical to my research. You are an active member in-home healthcare, providing the study with the experience, knowledge, and insight required.

Procedures

If you volunteer to participate in this study, you will be asked to do the following: answer research questions about home healthcare and demographic questions.

Benefits of Participation

There may not be direct benefits to you as a participant in this study. However, we hope to learn how communication can be better enhanced in this industry.

Risks of Participation

There are risks involved in all research studies. This study is estimated to involve minimal risk. An example of this risk is stress, invasion of privacy and possibly feeling uncomfortable answering the question about your organization.

Cost/Compensation

This will be no financial cost to you to participate in this study. The study will take approximately 30-45 minutes. You will not be compensated for your time.

Contact Information

If you have any questions or concerns about the study, you may contact (Carl Burgess, Carl.burgess10@student.ctuonline.edu, 682-351-4527 and Dr. Alexa Schmitt alschmitt@faculty.ctuonlin.edu, 412-953-8408). For questions regarding the rights of research subjects, any complaints or comments concerning the manner in which the study is being conducted, you may contact Colorado Technical University – Doctoral Programs at 719-598-0200.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice. You are encouraged to ask questions about this study at the beginning or at any time during the research study.

Confidentiality

Data will be extracted from participant questionnaires and interviews. Upon extraction, information will be placed in a word document that is securely stored in a password protected computer, accessible only by the researcher and destroyed after one year.

Participant Consent

I have read the above information and agree to participate in this study. I am at least 18 years of age. A copy of this form has been given to me.

_____ _____

Signature of Participant Date

_____

Participant Name (Please Print)

APPENDIX D: PROTOCOL FOR INTERVIEW

Preparation for interview

1. Establish contact with organization, and query about willing to participate
2. Initiate and provide overview of study to participants
3. Explain purpose of the study by phone
4. Explain the time-frame of the study, and the commitment expected
5. Provide a demographic sheet (Appendix D) as screening document to decide the individuals that are suitable for participation
6. If the individual is not capable of completing the study or unwilling, inquire about other individual who may be willing in the organization
7. If the participant is acceptable via screening, contact the individual via phone, email or text to schedule face-to-face interview
8. Contact participant a day before interview to re-introduce and re-confirm interview

Procedure during interview:

1. Ask the participant if he or she is willing to sign consent form to authorize the use of their transcribed interview notes and data in the final study
2. Review purpose of study and informed consent
3. Produce and deliver confirmation letter and Informed Consent Form for signature
4. Obtain signed consent form
5. Provide any insight needed to the participant for the remainder of the study.
6. Ask participant to complete demographic questionnaire.
7. Use digital recording device, as well as taking notes
8. Conduct questions, and ask for feedback
9. Respond to any question the participant may have
10. Provide participants with copies of the signed consent forms
11. At the end of the interview, thank the participant for participation in the study and give him or her a copy of the completed dissertation, after completion

APPENDIX E: INTERVIEW

1. Tell me about a situation when your manager did an excellent job of describing a patient assignment to you.

a. What did he or she specifically do to communicate the needs of the patient and the assignment effectively?

2. Please tell me about an opposite type of situation or scenario. How would you contrast the two scenarios?

a. What is the typical experience?

3. How does your facility evaluate important measures such as medication compliance?

a. Can you tell me about a time where you were involved in this process?

4. How does your organization communicate new or existing processes, to improve overall quality within the organization?

a. Could you please provide an example of a recent experience?

b. Do you know how issues are identified to improve upon?

APPENDIX F: DEMOGRAPHIC QUESTIONNAIRE

This questionnaire deals with the home healthcare, and your involvement in home healthcare. Please take a few minutes to express your background and demographic information in relevance to the study. Your answers are important to the success of this study because it provides population diversification. You have the option to respond to each these personal questions or decline to answer. Thank you for your assistance!

What is your age?

- 18-30
- 36-50
- Over 50
- Do not wish to disclose

Gender

What is your gender?

- Male
- Female
- Do not wish to disclose

Race/Ethnicity

How would you describe yourself? (Please choose one of the following options):

- Pacific Islander
- Indian or Indian American
- Asian or Asian American
- Black or African American
- Hispanic or Latino
- Non-Hispanic White
- Other
- Do not wish to disclose

Highest education completed

What is the highest grade or school you completed?

- Grade 1 through 8 (elementary/middle school)
- Grade 9 through 12 (High school)
- College 1 – 3 years (Some college or technical school)

- College 4 years (College Graduate)
- Graduate School (Advance Degree)
- Do not wish to disclose

Employment standing

What is your employment standing?

- Management (Administrator)
- Clinical (CNA, Nurses, Physicians)
- Non-management (Staff)
- Do not wish to disclose

Home healthcare experience

Work experience (homecare facilities)

- Under 1-year experience
- 1 through 5 years
- 5 through10 years
- more than 10 years
- Do not wish to disclose

APPENDIX G: INTERVIEW RESULTS

1. Tell me about a situation when your manager did an excellent job of describing a patient assignment to you.

a. What did he or she specifically do to communicate the needs of the patient and the assignment effectively?

PI-1

Question 1: The participant stated, "When I send the provider out to the field, he gives detail to what expected to be done. I give them all the detail needed to provide excellent care for the patient."

a. "I communicate the assignment and give them detail to what expected to do. Listen to them to ask questions and make sure they understand what is specifically expected". He said, "it could be understanding patient or section, must have detail before leave office and go for that assignment."

PI-2

Question 1: The participant stated, "Situation where the patient had an incident, the manager will send a licensed person to access the situation. Nurse, LVN and or CNA can call and communicate the situation, like a patient not being compliant with medication. At that time, managers will go to the patient residence to ensure the patient safety, if needed get doctor and or police involve. Staff must communicate with management, to ensure patient safety."

a. "The key is telephone calls, which are recorded on forms that tell what is going on with the patient. There is also documentation to communicate what is going on with the patient…. i.e. patient vital sign. Management can look at the documentation to

see if intervention is needed. One of the main sources of communication is the nurse aide calling the office when there is a change of condition. It is a means of communication because they oversee the documentation."

PI -3

Question 1: The participant stated, "When they sit you down and tell you everything about the patient before you go out. Management explains it before they allow you to go there."

a. Specifically – "Management will review the procedures, verbally and describe things by giving you the list of the things to describe."

PI-4

Question 1: The participant stated, "They did good jobs in most cases every time. The format they use to communicate is 4 to 5 physician order that gives the LVN nearly everything that is needed."

a. "You have what you suppose to do for a patient and what the patient need. The 4 to 5 shows the diagram of the patient regarding the medication, even if you are not there."

PI-5

Question 1: The participant stated, "We have the order sent out to the doctor, and the Nurse went ahead and did all the necessary assessment on the patient as well as the paperwork. Everything regarding documentation, record management was very diligent in getting everything by step as the order regarding the paperwork for the office. Which was excellent with the field worker, the staff, and clerical apartment as well as getting all the proper documentation for the patient chart."

a. Specifically, “when you meet the patient you know what insurance the patient has and medication, which is key such as when the doctor call and request vital information can be easily passed to the doctor. Also family background event of an emergency so we will know who to contact.”

PI-6

Question 1: The participant stated, “When management called and had a new patient, they told me the location of the patient. Management explained the medical part including medication and patient sickness.”

a. “Because he was at the patient house, showed her how to handle the patient. How to communicate with the patient, when he is agitated or refusing care. Did a one on one demonstration of how to handle patient.”

PI-7

Question 1: The participant stated, “My most current patient the way she got put into the program told me about her personality, disabilities needs and things of that sort. Had a very good personal communication with the patient/client and related that personal relationship with myself in giving me the assignment. Great communication between myself and the client is very important.”

a. “Personally introduce myself to the client. It was three of us, and we introduced ourselves to the client to develop a relationship.”

PI-8

Question 1: The participant stated, “As the administrator responsible for the clinical assignment of the office, the LVN, and Aides.”

a. Specifically – "communicated to staff through verbal, telephone, e-mail and test to provide proper assignment."

PI-9

Question 1: The participant stated, "I work on the weekend and one of the weekends we were short of staff, so my job was to reshuffle and resign employees and provide maximum patient care. We communicate those issues by calling individual and reshuffling staff."

a. "As a nurse sometimes I must get involved and take off that of CFO and get involved to fill in in that position, the manager at times has to get on the floor and give the same care hands on communication. This is done until they relieve me, and I go back to my managers position. We practice hands-on communication for everybody."

PI-10

Question 1: The participant stated, "Admitted a patient, through notifying the nurse by K-mail (used on a secure website). A full description of care was given through K-mail service and a follow-up phone call for wound care and how to communicate to the family."

a. Specifically, "called and gave a full report on wound care and how to communicate the care."

PI-11

Question 1: The participant stated, "The first thing the manager will do is give you a plan of care (written doctor order), which is a full description of what is going on with the patient what is needed and goal of care. It provides me with an excellent description of the assignment."

a. “They will tell you specifically what the patient need is, because everyone is different in home healthcare. The physician will tell you what the patient need and how to go about it.”

PI-12

Question 1: The participant stated, “They always do because before you take on medication, you have to have a brief overview of the patient process. Management does this by issuing out a plan of care which is verbal and or written.”

a. “Specifically go out and assess the patient and from their assessment do a plan of care. Then from the plan of care access an order to take care of patient.”

PI-13

Question 1: The participant stated, “She had a patient that need to have a daily visit. She was giving the demographic and detail information including the pharmacy, background, company and primary provider information including the shot kit that need to be in the patient home. This was communicated from the physician by giving the hospital discharge paper and or plan of care.”

a. The participant exclaimed, “The physician gave me all the necessary tools needed, including the patient information to be able to take care of that patient.”

PI-14

Question 1: The participant stated, “Normally we communicate through e-mail, we have an interdisciplinary conference once a week for all staff.”

a. “We usually type of diagnosis and what type of disciplines patient need in the home, verbal or via e-mail to the staff.”

PI-15

Question 1: The participant stated "My supervisor calls me a couple days before, which is helpful in setting up an appointment time. She gives me all the relevant information. Is better to receive a phone call than text information to receive all the information."

a. Specifically, "the communication is done via phone call."

PI-16

Question 1: The participant stated "Don't know of a particular situation. But in general, the manager gives a good report on diet and mobility of the patient. Communication is done via phone or face to face."

a. "They told me about the patient, who the patient lives with or if they live alone. Also how well they perform, what can they do for themselves as well what their needs will being and general living. Moreover, medication compliance and who prepares the medication".

2. Please tell me about an opposite type of situation or scenario. How would you contrast the two scenarios?

a. What is the typical experience?

PI-1

Question 2. The participant stated, "There are times when nurses get impatient and tell you they understand what has been told by management. However, when they get to the patient, you find that they were not listening. Tell them that you will have this device, but they'll call and say that they're not familiar with the device, which means they

weren't listening because you verbally explain. In that case, if the patient life is endangered, at the time you must go and perform the infusion yourself."

a. "Typical experience communicating with the nurse - Not paying attention happens among nurses often. Documentation falls short of what you want them to do. They do not document it right, and it becomes guess work."

PI-2

Question 2: In response the participant stated "It was a situation when the patient fell and the nurse did not inform the office. The family called the administration because the patient had a fracture."

a. What is typical experience – "Two-way communication; management has to set up the expectation and staff has to follow through with instructions. At times, there is a fall out which then is overseen by state governing body."

PI -3

Question 2: The participant stated, "No scenario for opposite situation for communication".

a. "Typical situation explained by the participant, Management tell you the patient is so in so condition, and this how you going to do it. You will review the background and history of the patient to bring up to speed to what needs to be done."

PI-4

Question 2: The participant stated, "Sometimes when you go in you may see more than what is expressed, so you have to go back and communicate with management. So when to go back for certification must add it to the next 4 to 5 to update the physician

order form (i.e. update medication), which is communicated by physician back to the management, through CREDO MRS software or via phone call."

a. Typical experience – "At the beginning a patient may be on IV, do lab work, and the lab work may see high reading, you then communicate to doctor for the decision, such as reducing the medication. At this time, they will get a new order and the medication changes."

PI-5

Question 2: The participant stated, "We didn't have an updated medication for the client. Doctor call and ask for that information, and we didn't have it and not done or forwarded to the office by the clerical department."

a. "Typical well see things such as medication change. Most time an anemic patient medication will be changed. It is required that every medication taken is updated by the office so that we can reference it. Also, the patient may have to doctor's, and they may choose to go with this doctor. So we console both physicians and get the proper medication plan."

PI-6

Question 2: The participant stated, "Management just call you and tell you we have a patient here and here and this is the address. Does not explain to you the patient needs and how the patient behaves. It is different in when the patient is there, just calling makes it difficult, because you don't know where to start, and no initial training on what is a need to be done."

a. The participant states. "Typically you don't have proper communication, and you find that you don't have what you need. Don't know if the patient can work certain

things by themselves, like a recliner, shower charge. Typically go to the home blindsided."

PI-7

Question 2: The participant stated, "On an occasion he had to assist immediately another patient and didn't get the proper patient introduction. Patient refuse to meet and assist (communicate with the manager, myself, and physician). The patient knows the care provider on a one on one bases establish much more relationship rapport than meeting someone randomly and asking for assistance from that care provider."

a. In response the participant exclaimed, "Meet the client, assist the client and care out the requested task."

PI-8

Question 2: The participant stated, "Communication is sometimes given by leaving a note or message to the individual. There is no formal device; communication is person to person or leaves a note or message with manager in the office to pass on to the individual."

a. "If the assignment is not done or carried out, you want to communicate with the people involved in the assignment. We do this so a correction can be made to the document, if a visit is needed to be made."

PI-9

Question 2: The participant stated, "There was no opposite time because it will create anxiety and will provide negative communication. Which is why the manager must at times get on the floor and provide the communication needed."

a. “Typically nurses or CVN are on staff, such as the Director of Nursing which can also pass medication.”

PI-10

Question 2: The participant stated, “I had a patient who feels a couple weeks ago with a contusion, and it was deeper than described to her by management”.

a. “Usually, communicate over the phone, providing a full report, also using stickers to communicate. Everyone who sees this patient get specific instructions on the patient via sticker (the sticker acts as a note, for example, the patient goes to dialysis three times a week) K-mail is primarily used to transcribe communication.”

PI-11

Question 2: The participant stated, “When there is no plan of care, you have to go and take care of this patient, and communicate the need for the patient. The family is there most of the time to tell you what is going on. You ask specific questions to find out what is needed or going on with the patient”.

a. The participant stated, “Typically when you go to the patient residence you have a plan of care. From here you have the equipment of material needed such as wound care to take care of patient.”

PI-12

Question 2: The participant stated, “There is little chance of having an opposite scenario – we are talking about people life, so they are very careful in this plan of care.”

a. “When you go out in the field the patient is always willing to have the nurse come and provide knowledge in taking care of themselves, so they rely on the nurses.”

PI-13

Question 2: The participant stated, “Don’t have the patient information or patient record to know what medication she takes. The patient didn’t know her doctor name, her medical problem or medication usage. This happen because of the lack of communication between the Director of Nursing and the field staff (clinician).”

a. “Normally when the patient is assigned you to have the patient demographic, the patient record, and the assignment. You have open dialogue from the Director of Nursing who provide the information needed for coordination of care.”

PI-14

Question 2: The participant stated, “Not everybody on the care team or the inner discipline team for the patient gets the information. If communication is shared with the nurse and not the therapist, there is a lack of knowledge regarding the patient and care that they need, because certain disciplines are left out of the loop of communication.”

a. “Typically if communication is not provided a patient or family member will complain if there is something questionable or lack of communication. For example, if the nurse does not communicate to the physical therapist, the family member may have questions regarding the physical therapist understanding, etc.”

PI-15

Question 2: The participant stated, “Text messages (K-mail) are not helpful because don’t get them right away. Depending on what area you’re in don’t receive all the information. In a comparison of the text message and phone call it provides a different level of patient needs.”

a. Typically – "K-mail is normally widely used to communicate issues. Everything is done in this computer system, so we (all staff) communicate within that system."

PI-16

Question 2: The participant stated, "It has been times I did not get the full report. May have time patient had a wound and did not know about it. The breakdown in communication sometimes goes through a third party."

a. Typically – "When I go out to the patient home introduce myself and see how they are doing. I am there to understand their knowledge base about their disease and medication. This gives me and understanding of what I need to teach them. The nurse who admitted that patient to service typically provide information through her determination on what the patient needs. However, the communication is not all inclusive, and we have to come with a plan of care of what the

patient needs."

3. How does your facility evaluate important measures such as medication compliance?

a. Can you tell me about a time where you were involved in this process?

PI-1

Question 3. The participant stated, "Evaluate important measures – We interview the patient and find out how much knowledge they have about their expected to take their medication. If they found they are not taking their medication or not have the ability or capacity to take medication as ordered, then you take the medication from them and call them via phone and ensure their taking proper medication regarding the proper medication according to the color coding set up."

a. "Now and then the manager must call the patient and see if they are taking their medication today. They may respond, and you find out they are taking it wrong. This is reported to the doctor in regards to the problems they have, i.e. memory problems."

PI-2

Question 3**:** The participant stated, "Medication compliance is important when there is non-compliance the patient will seek acute care at the hospital. We have a pillbox that is labeled appropriately regarding when they take it. We fill the pillbox out for the patient weekly and ensure the patient is compliant. We check it every day, to determine if the patient has been taking medication. At times we do lab work to determine if the patient is being compliant and taking his or her medication."

a. "I still take care of the patient and ensure the pillbox is accurate. It is essential that medication compliant is monitored by the home health. Expectation is to have a good management."

PI -3

Question 3: The participant stated, "You go their concerned about if the patient is taking his or her medication, as the doctor prescribe. You check each time on a visit to make sure the patient is in compliant with taking medication".

a. "You are involved in every visit regarding making sure medication is in compliant."

PI-4

Question 3: The participant stated, "It depends on if the medication is being controlled. If the patient is getting itself, you must rely on the patient word if they take it.

For instance, you monitor by going in and see if the medication is being taken "if pills are gone they are, if not they are not".

a. "Every time, you must fill in the form if the patient is compliant or not. The form is called the daily nursing not, which is filled out anytime you go to the patient home. This is a manner of communication between each party doctor, nurse, and administrator."

PI-5

Question 3: The participant stated, "What we tend to do is keep a record for patients when come out to visit. This is a form that is updated on a visit and transferred to patient chart. Another thing is periodical to consult the patient in medication; call the doctor and see if there is a change in dosage or if there is going to be a change. The form used is called the medication reconciliation form".

a. "When we do quarterly audit charts, we go through the process note and pick out things that are on there to make sure patient receive proper medication. If not in their called this to the Nurses attention."

PI-6

Question 3: The participant stated, "Don't know how they do it. I think it is perfect because the nurses talk to the patient about medication given. And as a CNA my part is to remind the patient about taking medication".

a. "Involved in medication compliance; every time I go, I remind the patient of taking proper medication."

PI-7

Question 3: The participant stated, “Follow up with the doctors. If there is a concern for the patient, reflect that concern to the tent, and then we follow up with the establishment; so communication all around.”

a. “With my patient now, so the patient had a medical need and had some reaction to medication, communicate how she feel and communicated to the fellow nurses via one-on-one conversation with nurses in establishment.”

PI-8

Question 3: The participant stated, “The way it is evaluated, we follow and abide by the medicated standard rule and regulation. We compare our standard to Medicaid rules and regulation.”

a. “Involved in yearly evaluation; patient and employee evaluation.”

PI-9

Question 3: The participant stated, “Do a random audit, so if you are a clinician who passes medication, you may randomly select how the medication is given, i.e. have 50 patients, randomly select ten which is one way to audit”.

a. “Involved in the process by giving random audits i.e. ten a month.”

PI-10

Question 3: The participant stated, “Basically, we work on that on a weekend basis make sure the patient is compliant every medication is being used, and nothing is missing. We give them a pillbox to put the medication, and teaching them how to use the pillbox, ensuring they take it properly.”

a. “Often are involved in this process, do it when I go and see a patient. Have a list of what medication is needed and review a list from the doctor. If they have a pillbox, review the pillbox and show them how to use it.”

PI-11

Question 3: The participant stated, “We teach the importance of compliance and consequence of taking medication by setting up a pillbox, and teach them what to take in the morning or evening Monday through Sunday.”

a. “Involved all the time in compliance, by communicating with a physician, and talk to the patient about compliance as well as teach them about regimen.”

PI-12

Question 3: The participant stated, “The nurse asks the patient for all the medication being taking over the counter and prescribed. They come back and compare it to what the doctor is giving them. Some patient has more than one position, so we much communicate that to ensure their not taking double doses.”

a. “This process is carried out and verify it to ensure to discrepancies. So every time you go out to see the patient, you must compare and contrast medication.”

PI-13

Question 3: The participant stated, “Medication of compliance is one of our core values when it comes to home health and necessity. The first time nurse evaluates the patient; the nurse will have a complete review of the patient medication. As soon as the nurse capture the release of all the medications he or she will verify the medication with the doctor. As the doctor authorize the use of that medication, the nurse goes to the home

and monitor the medication and count the medication each visit. You will be able to know what the patient has taken from the last visit (in compliance)."

a. "Allot of the patient is not in compliance with medication, they forget full and don't understand the reasoning because the hospital didn't educate them on the medication. This is why the home nurse is there to educate them on the importance of medication compliance."

PI-14

Question 3: The participant stated, "The nurse evaluates case management and patient medication every business. The nurse evaluates patient compliance. If there is a PC, only care the physical therapist evaluate it consulting with the nurse-patient compliance in the field. The tools we use in communication are a phone, e-mail or verbal communication. Everything is documented electronically as well as email."

a. "Recently I evaluated a patient to be admitted for healthcare, and she had medication everywhere and tried to regulate them and take it herself. That didn't go over well, so I reconciled all the medication and put them in a medication weekly planner. I then constructed the caregiver and reconciled what she had with the primary care physician."

PI-15

Question 3: The participant stated, "Can't answer that I don't work with medication."

a. "Not involved in this process as a CNA."

PI-16

Question 3: The participant stated, "We have to go in and look at every single medication in the home. Go over it with the patient and evaluate how they take it. We identify the medication and teach them the side effect of medication and drug interactions."

a. "It is an ongoing process that is communicated through assessment once a week. Ask the patient about their medication and usage, through documentation every week."

4. How does your organization communicate new or existing processes, to improve overall quality within the organization?

a. Could you please provide an example of a recent experience?

b. Do you know how issues are identified to improve upon?

PI-1

Question 4: The participant stated, "Communicate - In-service training every two week and case management. All nurses come in and give an account of patient management. Every two weeks, in-service training and case management, all nurses are expected to call in and give updates. Also, we use e-mail software to communicate patient needs and updates."

a. "Use ICD-10. Send workers to workshop and develop a superuser, who can train other personnel on the software on what to do. The director goes through every assessment that comes in and make sure it is in appliance with the guideline, i.e. using the ICD-10."

b. “Using bottom-up communication, Nurses pass information to the officer manager, up the ladder to the Administration. The solution for communication is and up-down method.”

PI-2

Question 4: The participant stated, “In-service is performed every two weeks or pays day to update the staff on what is current.”

a. “Today, we organize in-service on infection control by KCI does wound control); the company representative does a demo i.e. new IV pump to update skills. Also, do an annual skill assessment and proficiency of staff. At times we hire outside vendors to train staff if new certification is required.”

b. “Issues are identified - We do supervision with staff to identify situations and issues. Encourage patients to give us feedback to let us know if nurses are having difficulties with issues best tool.” Higher an independent body, who do a survey “mandatory from state.” “Internally set up a situation where we call clients to get feedback and identify the issue. Also, go with nurses on the very first visit to see how comfortable they are. Also, follow up with the patient to see if the new nurse is ok, and see if they understood the procedures. This helps to find out what they strength and weaknesses are as well as comfortability, and what needs to be improved upon (conduct SWOT analysis).”

PI -3

Question 4: The participant stated, “Do orientation on it with staff and tell you the situation of the patient that is coming in. This is how you roll with it. They tell you by reviewing how you will deal with it.”

a. For instance, “when you have a patient with HIV, ensure that you are careful; wear gloves wash hand be cautious of that.”

b. “Management identifies situations to improve upon situations and issues.”

PI-4

Question 4: The participant stated, “Communicate through in-service, a lot of in-service tell what’s going, what need to be changed, etc.”

a. “Today in-service was with KCI (bandage wounds), which updates us on improvement process and what need to be doing to improve procedures.”

b. “Problem solving go to the patient and see what’s going on and report back. If there is no standing order “pre-authorization from doctor” then you call the doctor and see what he or she wants to be done.”

PI-5

Question 4: The participant stated, “We can send out communication or have and in-service (training). If it is brand new information, in-service is used for updating. If information and issue needs to be immediately acted on, then it can be a simple phone call.”

a. “We have what we call a QAPI quarterly report to see if expectations for each quarter has been meeting by using QAPI.”

b. “To improve upon issues by using QAPI and doing a chart review to improve upon for next quarter.”

PI-6

Question 4: The participant stated, “If something is not working if there is a change they and inform you. You come to the office, and they explain the change. Knew process is explained one-on-one in the patient home and the steps needed.”

a. “Continue the same process there is no change.”

b. “The issue is identified most through the people in the field (CNA) they call and administration and say this is what happens, and they fix it from there.””

PI-7

Question 4: The participant stated, “Through communication and hands on, if something needs to change go directly to the source. Training is done if necessary, if not it is communicated by word of mouth through physicians. Communication is done primarily verbally; no standard methodology is used regarding communication.”

a. “The antibiotics that patient is currently on we been working hand to hand to make sure the client is efficiently and comfortably taken care of, by communicating to with the doctors. Physicians reach out with communication as well, by phone calls and office visit or come out to the client residence and communicate personally that away.”

b. “How issues are identified – keep a close eye on a patient we communicate and speak to them on how things are gone.”

PI-8

Question 4: The participant stated, “By staff in-service which is given monthly or as needed

a. For example, is when we did training in in-service for Medicaid changed coding from ICD9 to ICD-10.”

b. “By quality improvement, chart review and evaluation. Issues are often identified by any person in the field and pass on to the manager for improvement.”

PI-9

Question 4: The participant stated, “By doing in-service at a 2-week time frame, to determine what is needed and update training needs.”

a. “Recently did in-service last Monday, which checked on how the medication is provided to patients.”

b. “Do room to room rounds every morning notating them on pen and paper, to see if there are any issues needing addressing and improvement upon.”

PI-10

Question 4: The participant stated, “Use the phone mostly and use the K-mail (secure site) or memo to communicate something specifically. If there is an issue, the provider calls the administrator (her) directly.”

a. “New process implement – cover new process by going to classes and provide the nurses with cheat sheet when need fill out their information.” Recent experience a few months ago was the training to inform the change of the ICD9 to the ICD10.”

b. “We identified issues through paperwork, and standardized testing identify the problem and send information, and talk to a physical therapist to see if in-service is needed to make the service better. Or do we need to provide new equipment to make the job easier?”

PI-11

Question 4: The participant stated, “Do in-service, every two or three months, also mandatory training every ten days to keep addressed of the changes.”

a. “Recent in-service was given on seizure what to expect and what not to expect regarding seizure medication etc.”

b. “Sometimes it is identified by taking notes of the patient and having an awareness of what’s going on around you. The person there, such as the nurse, identify the issue(s) and send it to the physician/doctor and have awaited their approval, before implementation. The issue itself is normally identified by the person who are currently on station and then that person talk to the physician about it.”

PI-12

Question 4: The participant stated, “There is ongoing training such as in-service training to keep abreast on what is going on in the industry. Management also must attend symposiums to keep them abreast of training.”

a. “Recent event is the new change from the ICD9 to ICD10 and billing and coding process. All aspects of healthcare are affected with this change; everyone must have knowledge on this change.”

b. “Employees are giving satisfaction survey, based on that they can tell what they are satisfied and not satisfied with; this form is given to the patient and employee to improve upon in issues.”

PI-13

Question 4: The participant stated, “One of the requirement is to have a home health license Texas is three-month quarterly audit and also have what is called PACT group who review services. We audit auditor and have an office audit, and mention nurses note the state of care. We have performance improvement processes called

Quality Improvement Inventory, to rectify what the process is if there are any inefficiency."

a. "A few days ago a patient was not compliance with their treatment, so we had a conference call on what is beneficial to the patient. We explain to the patient on quality care and what we recommended for them. We use this process to ensure and protect them through safety processes."

b. "Identify issues by the compliance and audit committee. When the compliance committee go to the nurse's note, it is brought to the table for possible intervention. Issues are also identified through patient complaints, to provide a process to make sure issues don't happen again."

PI-14

Question 4: The participant stated, "We have a bill of performance project that we do quarterly for skill assessment. And we use and education consulting to monitor assessment."

a. "Recently the system use wasn't updating or showing the date of referral. This is the project that is being done to make sure it is updated."

b. "Identify issue through outcome measures, and improved upon through the performance improvement project with the entire staff. Out in the field spot checks are being done on employees where I'll go out talk with the employees and management then resolve the patent. Employee complaint will be identified and justified if complaint is justified."

PI-15

Question 4: The participant stated, “We have weekly meetings. K-mail is used, but if something changes, we have meetings as well as monthly meeting.”

a. “Very seldom do I get to sit it in on the meetings because I am always with a patient. We had a meeting we came up with the alert braces for the elderly. This is something that is something that was implemented into our agency that is given free of charge. The meeting was conducted to inform us on the process of setting it up. With any new process such as something that is changed with Medicare, they go over it in that meeting as well.”

b. “We discuss if we feel like there is there is a problem we discuss it in our meeting. That open dialogue helps us come to evolution on the issues. In the field, the issue is identified by the caregiver in the field, letting the nurse know.”

PI-16

Question 4: The participant stated, “Good communication is the best; having meetings help share information. We also have various training and meetings every two weeks, which are called case conferences that determine patient’s recertification. Discussed in the conferences are if the patient needs certain skills, if not he or she can then be discharged.”

a. “We had a patient conference last week. It is required by Medicaid, which we have to write up a 60-day summary. At the end of their admittance have to communicate patient health through the 60-day summary.”

b. “Normally if there is a problem we will contact the Director of Nursing, and then talk about what should be done about it. The clinical issue is discussed with the clinical supervisor.”