Journal of Interdisciplinary Undergraduate Research

Volume 12 Article 5

2020

Emotional Intelligence: Improving the Delivery of Quality Patient Care

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Abstract

Emotional intelligence (EI) is the ability to recognize one's own emotions and that of others when responding to a situation. It has a long-standing reputation for predicting positive outcomes in many fields and occupations. Emotional intelligence has also had a long-standing reputation for taking the backseat in education. Nursing is no exception. With many nurses having little to no knowledge of anticipating patient needs or what it means to be empathetic, it can impact the patient's perception of patient care. Often, the skill of being emotionally intelligent is either learned on the job through experience, innately in the character of the nurse, or never learned at all. Because there have been correlations with EI and quality indicators such as pressure ulcers, fall rates, and infection prevalence, it is important that emotional intelligence be a part of nursing education (Adams & Iseler, 2014). This literature reviews the correlation between high-quality patient care and nurses with higher EI in an effort to explore the benefits to patient care. By examining the clinical repercussions and outcomes in patients cared for by nurses with higher emotional intelligence, the healthcare and nursing fields will understand the importance of truly being there for patients, and that bedside manner could be a large step in the direction of high-quality patient care.

Research/PICO Question

Do nurses with high emotional intelligence deliver higher quality of care to their patients? Many hospital organizations and nurse educational facilities do not encourage the development and growth of emotional intelligence. By educating on its validity and effect on quality of care, hospital facilities can establish programs to help their nurses develop and improve their emotional intelligence.

Review of Literature

The research for this literature review considers the impact of high emotional intelligence on the delivery of quality patient care. Research criteria spanned from publishing dates between 2013 and 2018. The research was accessed from databases provided through the McKee Library, including EBSCO databases such as MEDLINE and CINAHL Complete, as well as through Google searches for non-database accessed information of credible websites. Keywords utilized in the process of this research include: emotional intelligence, nurses, empathy, patient outcomes, and quality of care. These terms were used both singularly and in combination with one another in order to yield the most pertinent and accurate results.

Description of Studies

Study One

Research design. Adams and Iseler (2014) conducted a quantitative study. This research study was a "correlational, cross-sectional design." It was used to examine the correlation of emotional intelligence with the occurrence of infection rates, patient falls, and pressure ulcer screenings.

Sample. The sample was taken from registered nurses working in an eligible unit who were bedside in their roles for at least one year and consented to the study. A total of 361 RNs participated in this study.

Data Collection. In order to measure EI, the participants completed the Mayer-Salovey Caruso Emotional Intelligence Test (MSCEIT). This exam assessed the emotional response of the participants to experiential emotions as well as how they managed and perceived emotions to provide an overall EI score. The five Quality of Care (QOC) indicators measured patient

outcomes such as falls, falls with injury, medication administration error rate, Clostridium difficile, and Methicillin-resistant Staphylococcus aureus. The QOC variables were calculated based on the percentage of incidents reported divided by the number of patient days. The five Compliance with Care (CWC) indicators reflected the nurses' expectations for care provision, which included adult pneumonia vaccination status screening, telephone/verbal order documented and read back, hand hygiene compliance, Braden screening compliance, and critical test response documentation.

Data Analysis. Researchers used SPSS to analyze the quantitative data. The variables in study, such as comparisons of demographic and EI results from participating units, were expressed through descriptive statistics. A multivariate linear regression analysis was used in order to demonstrate the relationship of EI in participating units and their QOC and CWC variables. A correlation analysis was also used to compare EI and patient satisfaction.

Limitations. The limitation in the research included the small percentage of nurse participation which affected the demographic and limited the data to female Caucasian nurses (Adams & Iseler, 2014). In addition, the MSCEIT was not entirely accurate, therefore limiting the validity to assess patient satisfaction. The study supported the PICO question which discussed the impact of nurses with high EI positively impacting patient outcomes. The study stated the determined that nurses in the study possessing a high EI score significantly impacted the quality of care being upheld by the hospital, supporting the research claim that nurses with higher emotional intelligence would have better patient outcomes and care.

Study Two

Research design. Araque (2015) conducted a quantitative study. In order for this subjective topic to be measured quantitatively, the Caring Factor Survey (CFS) was used, followed by a Likert type of scale to measure the variables from 1–7, one being the lowest and seven being the highest (Araque, 2015).

Sample. For this study, a random sample of 30 nurses assigned to medical surgical units were asked to voluntarily participate. The nurses and their patients signed a confidentiality agreement. The participating nurses were varied in experience, cultural backgrounds, and education levels either with an associate or bachelor's degree in nursing. They could be working either night or day shift (Araque, 2015).

In addition to the nurses, a sample size of 60 inpatients were used: "two patients cared for by each nurse participants were asked willingly to participant and enroll in the study" (Araque, 2015, p. 59). "The patients were limited by the following criteria: a) received care from the nurse participants for at least one 12-hour shift (day or night); b) alert and oriented; c) between 30 to 65 years old; d) able to consent to participate in the study; and e) willing to use an interpreter as needed to understand and answer the questions on the survey" (Araque, 2015, p. 59).

Data Collection. The data collected utilized two valid data collecting instruments. One of the instruments used was the Caring Factor Survey (CSF), which "measured patient perception of nurse caring behavior" and was given to participating patients after receiving care from the participating nurse (Araque, 2015, p. 61). The CSF was translated to Spanish to allow Spanish speaking patients to participate. The surveys were confidential, "numbered and given at random to keep surveys anonymous" (Araque, 2015, p. 61). The second method was MSCEIT; it

measured the nurse's level of emotional intelligence. The test was completed online by the nurses. The MSCEIT scored each of the "four dimensions of emotional intelligence" framed by a model from 1999 (Araque, 2015). The test allowed for assessment of nurses' ability to respond to emotions as well as utilize emotions. After scores were obtained and interpreted, the results were used to "compare the levels of emotional intelligence with the themes of the CSF from patients" during their hospital stay (Araque, 2015, p. 62).

Data Analysis. The MSCEIT test results were given to a third party, Multi Health Systems, which dealt with the interpretation and scoring of the EI assessment data. The type of data collected by both the CFS and MSCEIT tests were interval data (Araque, 2015). Pearson's correlation coefficient was used to describe the degree of correlation between a nurse's level of emotional intelligence and the patient's perception of nursing care. Regression analysis was also used to identify which dimension had a correlation to nursing care perception (Araque, 2015). The computer software SPSS was used to manage the obtained data from patient surveys.

Limitations. The research discussed a few of the limitations in their findings, some of which are the inability to assess the integrity of nurses' self-reported answers in the MSCEIT (Araque, 2015). This could contribute to skews in validity of EI scores and the percentage of nurses with a high EI. The second limitation was the reading level of the CSF survey differing from the reading level of the participation patients (Araque, 2015). Thirdly, the sample only included nurses and patients in the Medical Surgical Unit (Araque, 2015). Another limitation was consistency of care. Due to shift changes, there were participating nurses of different EI levels caring for the same patient (Araque, 2015). Lastly, the limitation in published research

exploring the specific relationship between the aspects of a nurse's EI and the correlation with patient-perceived caring behaviors by the EI nurses (Araque, 2015).

Study Three

Research design. Bailey, Murphy, and Porock (2011) conducted a qualitative study. It is appropriate for this kind of research because quantifying emotions, bereavement, and other aspects of mental states is difficult to accomplish. Qualitative approaches allow for themes to be addressed based on open-ended questions asked of the patients and nurses. Following this theme in the study proved to be an effective way of obtaining emotional intelligence data.

Sample. "Over 900 hours of unstructured observations were conducted over twelve-months in all areas of the emergency department to observe accurately the 'backstage' as well as the 'front stage' behaviors of emergency staff" (Bailey, Murphy, & Porock, 2011, p. 3365). Interviews were conducted within the 12-month period on 10 staff members, including five nurses, two doctors, one student nurse, two emergency department assistants, as well as patients who experienced an emergency department admission within six months (six admission patients) and their relatives (seven family members). Inclusion criteria was involvement in the ED, with patients admitted once in the previous six months, family members of those patients, or ED staff directly involved in the care of a deteriorating or dying patient (Bailey et al., 2011, p. 3365).

Data Collection. Natural interviews and informal interviews were conducted among ED staff and noted as objective data. In addition, "in depth interviews were conducted three months after starting the observation" (Bailey et al., 2011, p. 3365). The interviews were all digitally recorded and transcribed. The qualitative study drew on ethnographic methods to conduct this study. Strategies to ensure reliability were not mentioned in the research study.

Data Analysis. The recorded and transcribed interviews were all "coded in Nvivo 7 and analyzed thematically alongside the observational data" (Bailey et al., 2011, p. 3365). The researcher did not examine their role in the data. The study did not state whether or not data was analyzed inductively or if data saturation occurred.

Limitations. While the article did not directly address limitations in their conducted study, its results are relevant to clinical practice in registered nurses with high emotional intelligence. As stated in the study, "The nurse first has to invest the therapeutic self into the nurse–patient relationship to develop the intuitive skills associated with recognizing deterioration and the individual needs of the patient as death nears" (Bailey et al., 2011, p. 3370). When forming relationships with patients and their families, especially in end-of-life care, nurses become adept in watching their patient's status and anticipating their physical as well as emotional needs. As a result, nurses with higher emotional intelligence can create a better outcome for patient care, a comfortable environment, and a better patient and family experience in a clinical and often traumatic setting.

Study Four

Research design. Giménez-Espert and Prado-Gascó (2018) conducted a fuzzy-set correlational qualitative study. In this study, self-reporting was used by surveying. Trait Emotional Meta-Mood Scale and Jefferson Scale of Nursing Empathy were used in this study to obtain results (Giménez-Espert & Prado-Gascó, 2018).

Sample. A sample of 460 nurses were used in this study to take the survey. These participants were taken from six area hospitals in Valencia, Spain. The nurses were required to be currently active in their employment (Giménez-Espert & Prado-Gascó, 2018).

Data Collection. To collect the data, researchers at the local hospitals in Spain were used. This process went from September 2015 to February 2016. The survey took about 35 minutes from start to finish for the nurses to complete. Once completed, they were picked up by researchers (Giménez-Espert & Prado-Gascó, 2018).

Data Analysis. This study was done in a two-part survey. The first section was instrumented by the previously mentioned scales. This section was calculated through descriptive analysis, and then hierarchical models were obtained. Once the values were calibrated in the analysis, the raw data from the participant's responses were analyzed (Giménez-Espert & Prado-Gascó, 2018).

"The FSQCA 2.5 software by Claude and Christopher (2014) recalibrated the values of each variable considering the three thresholds (Woodside, 2013): 10% (low agreement or fully outside the set), 50% (intermediate level of agreement, neither inside nor outside the set) and 90% (high agreement or fully in the set)" (Giménez-Espert & Prado-Gascó, 2018). Condition tests were then used to evaluate the empathy and EI of the nurses (Giménez-Espert & Prado-Gascó, 2018). After these tests were conducted, IBM SPSS Statistic 23 Program was used to calculate the hierarchical regression, then the FSQCA 2.5 Software was used to calculate the FSQCA (Giménez-Espert & Prado-Gascó, 2018).

Limitations. One of the mentioned limitations in the study is that it took place only in Valencia, Spain. Without a variation of locations, the study is not as accurate as it could be. The study suggests that in the future, using other locations in addition to the home location could alter the results (Giménez-Espert & Prado-Gascó, 2018).

Another bias noted was the self-reporting aspect of the study. Though it is common to have self-reporting in studies, it often brings out biases that go undetected, which may alter the

results. They recommend this be in mind for future research (Giménez-Espert & Prado-Gascó, 2018). This study conveys the importance of emotional intelligence in the nursing environment and how it can alter communication with patients and other nurse staff.

Study Five

Research design. Codier, Freitas, and Muneno (2013) conducted a "mixed method, pre/post-test design" study (p. 24). This study appears both quantitative and qualitative between surveys and informal interviews.

Sample. This study used a sample of 33 RNs working on a 24-bed inpatient oncology unit in urban Honolulu, HI. The study mentions that only 10 of the 33 RNs provided demographic information, but all were able to fill out the entire survey. The staff represented a broad variety of cultures and ethnicities, as well as all kinds of employment. Nurses could be working full-time, part-time, as a charge nurse, or just staff. The only requirement was that participants be registered nurses (Codier, Freitas, & Muneno, 2013).

Data Collection. The data collected by the participants were taken electronically. The internationally prevalent EI test, Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT), was used to survey emotional intelligence in the RNs. A less reliable reporting tool was used to measure energy and mood in the sample: RNs rated their self-reported energy and mood, and also a nurse satisfaction survey was used by the hospital. In addition to the surveys, the RNs were "asked three questions: (a) 'What is going on emotionally with your patients today?' (b) 'What is going on emotionally with you today?' and (c) 'How do you deal with difficult emotions related to work?'" (Codier et al., 2013, p. 25). From this, researchers took responses and analyzed the qualitative data for themes.

Data Analysis. The information was analyzed with SPSS version 16 for frequencies, central tendency, and standard deviation. The demographics of the RNs were analyzed with the MSCEIT test with chi-square, Spearman's rho, zero-order correlations, analysis of variance and sometimes multivariate ANOVA. Responses on the qualitative data were analyzed with Q-sorts and finding themes (Codier et al., 2013).

Limitations. A limitation mentioned in the study was the demographic characteristics specific to Hawaii. The researchers felt the data was missing significant demographics. Because of the lack of participation it is hard to draw accurate conclusions. In addition, the study was self-reported, which could taint answers with unintended bias. The researchers were also concerned about the anonymity of the RNs involved: The informal interviews were conducted at public huddles on the unit and they were, therefore, not private (Codier et al., 2013). This study resulted with "94% of RN participating in EI rounds, positive (100%) evaluation of the impact of rounds, and improvement in emotional care documentation and planning" (Codier et al., 2013, p. 27). With this in mind, the conclusion can be made that being emotionally aware and intelligent of patient's current mindset and outlook on life can impact the patient care received (Codier et al., 2013).

Study Six

Research design. Celik (2017) conducted a cross-sectional quantitative study. This study aimed to "determine the relationship between the use of EI skills by nurses' surgical clinics and patient satisfaction during hospital say, and also assess the importance of EI skills" (Celik, 2017, p. 1364).

Sample. This study used 79 consenting nurses employed at various clinics, including cardiovascular surgery, urology, orthopedics, traumatology, plastic and reconstructive surgery,

neurosurgery, gynecology, and thoracic surgery all at the same hospital. A total of 113 inpatients who chose to participate were surveyed in each of these clinics (Celik, 2017).

Data Collection. The data was collected by self-report on an Emotional Intelligence Scale of 33 items. It was developed initially on the Schutte Scale to measure psychometric properties. The measurement was based on "empathic concern, emotional regulation/management, utilization of emotions, and emotional awareness." The scale was based on Likert-type choices (Celik, 2017, p. 1364).

The second aspect of the survey was the NCSS. It consisted of 34 items and evaluated the patient's satisfaction with the care they were receiving from the nurse (Celik, 2017).

Data Analysis. The data was taken from the returned surveys and analyzed with SPSS. The "Kolmogorov-Smirnov test was used to assess the normality of the distribution. The Mann-Whitney U Test and Kruskal-Wallis H tests were used to determine statistical significance" (Celik, 2017, p. 1365).

Lastly, the Pearson correlation was used to determine the outcome of significance of the correlation between patient satisfaction scores on the NCSS and the EI test of the nurses. The test determined that the results were statistically significant (Celik, 2017).

Limitations. This study was done on a volunteer basis by all participants. All permissions were granted from authorities to conduct the study. No limitation or conflicts in the work were listed by the researcher. This study supports the research question of whether patient satisfaction of care is correlated with nurse emotional intelligence (Celik, 2017), and suggests that emotional intelligence in nurses can directly impact patient care and perception of empathy. Furthermore, it can impact the health of the patient and aid the nurse in providing quality care.

Findings

The articles studied provided evidence of a positive correlation with a nurse's emotional intelligence and high quality patient care. The results of these studies highlight the need to educate and encourage nurses and nursing facilities to develop EI as a skill that is just as vital as theoretical nursing knowledge. The ability to identify emotions in a patient and respond accordingly allows for better patient outcomes by not only providing patient satisfaction through comfort and understanding from their nurses, but by helping nurses be especially attentive to preventing nosocomial infections/illness. Adams and Iseler (2014) conducted a study focusing on emotionally intelligent nurses' ability to deliver quality care and promote compliance with care. The researchers' results demonstrated a decrease in C. difficile infections incidence, MRSA infections incidence, and patient falls with injury, and an increase in pressure ulcer screening as part of compliance with follow-up patient care. However, this study assessed patient satisfaction through a score system and the findings showed no significant correlation with EI and patient satisfaction. This study did suggest, however, that by increasing the EI of nurses, quality of care on respective units will increase (Adams & Iseler, 2014). Similarly, Giménez-Espert and Prado-Gascó (2018) researched how empathy and emotional intelligence influenced quality of communication between a provider and patient in times of stress. It was discovered that emotionally intelligent nurses were better able to smoothly ease the stress of their patients who later reported high patient satisfaction.

The studies conducted by Araque (2015), Bailey et al. (2011), and Celik (2017) focused on patient reports and scoring of satisfaction experienced during their hospital stay when cared for by an emotionally intelligent nurse. The research conducted by Bailey et al. (2011) emphasized the idea that though there may be instances when nurses are unable to establish a

patient-nurse relationship, doing so, has been recognized as a "key role in influencing the experience of end-of-life care for both the patient and the nurse" (Bailey et al., 2011, p. 3371). This specific study's research findings highlighted the importance of using one's emotional intelligence to establish a relationship and help a patient through the emotional end-of-life experience. Araque (2015) studied the correlation of nurses exhibiting dimensions of emotional intelligence and patient outcomes determined through satisfaction scoring. The conclusion was that nurses can exhibit one or more dimensions of emotional intelligence and still deliver positive patient emotional perception. The research as well as the emotional intelligence model identified are guides that can help leaders identify areas that need to be developed in their nurses. Celik (2017) determined that "emotional intelligence should be recognized as of the indicators to improve the quality of health care service" (p. 1367). The research in each study encouraged the idea of educating nurses on the development of their emotional intelligence and prompting education facilities and medical organizations to create resources and opportunities to enhance emotional intelligence and equip nurses with the tools needed to deliver exceptional levels of quality patient care.

Utilization of Research

Recommendations/Implications

The research demonstrated a need for more education on the importance of emotional intelligence in clinical practice. Nurses that exhibit emotional intelligence are able to deliver and exceed the standards of care imposed by their facilities. By simply training nurses to enhance one of the many dimensions of emotional intelligence, they are better able to deliver quality care readily. The research recommends that hospitals as well as nursing programs emphasize the teaching of emotional intelligence as they would the theory of nursing. Furthermore, the

researchers emphasized that nurses are ill equipped in handling emotional crises in patients, and though this skill could be developed overtime, novice nurses would greatly benefit from experienced nursing advice and training.

Application to Practice

Throughout the research presented, time and time again the idea of validating emotional intelligence as a component to clinical practice presents itself. Many of the researchers have recognized that when given the right tools, emotional intelligence can be developed and could greatly impact a patient's quality of care. In fact, by simply nourishing certain dimensions of emotional intelligence, one's ability to deliver quality of care can dramatically increase. The research has helped identify areas in which nurses can improve in order to acquire this skill. By adopting emotional intelligence, as well as other emotional competencies such as empathy, facilities can harbor "a positive work environment, and a satisfied sustainable workforce that improves quality of care and patient health" (Giménez-Espert & Prado-Gascó, 2018, p. 2670).

Application to Biblical Practice

In *Ministry of Healing*, Ellen White (1990) wrote, "When love and sympathy that Christ manifested for the sick is combined with the physician's knowledge, his very presence will be a blessing" (p. 245). God calls for us to use our gifts of knowledge along with love and compassion in healing practice. By doing so we are becoming that vessel that the holy spirit can use to bless each and every one of our patients. White (1990) also states that "Sympathy and tact will often prove a greater benefit to the sick than will the most skillful treatment given in a cold" (p. 246). More often than not, what has the greatest potential to heal patients is our ability to deliver compassionate care. Tact and sympathy are often overlooked in clinical practice but should be regarded as a tool to reflect God's love and legacy of healing.

Further Research

As healthcare practice is growing and nurses are increasing in demand nationwide, further research on this crucial skill for clinical practice should be conducted. Emotional intelligence affecting quality of care could be further studied by including a wider demographic such as nursing students, diverse acuity unit nurses, and nursing professors. In addition, a long-term study of a diverse group of nurses being trained to improve their emotional intelligence and studying the improvement of their delivery of quality care as measured by patient interviews and physiological patient outcomes would be greatly beneficial. Many studies discussed in this paper chose a female Caucasian demographic sample. More nursing minorities, such as males and diverse ethnic backgrounds, could be included in further research. By doing so, there is a better understanding of how emotional intelligence affects each demographic and what samples seems to lack the most development that could be worked on for improvement. Emotional intelligence is a vital skill to clinical practice that all healthcare providers should develop to deliver the best quality patient care.

Conclusion

Emotional intelligence has long been a predictor of positive outcomes in many fields, but does this translate to nursing? Do nurses with high emotional intelligence deliver higher quality of care to their patients? Many articles and literature reviews have been written to support the value of EI in nurses and the significant difference it can make in a patient's outcome and quality of care. Researchers have found that when with nurses are emotionally available and reminded of patient's emotional needs, their innate EI can make a positive impact in their daily shift assignments.

Though this soft skill set is not emphasized in training, preceptorship, or schooling, it is important that emotional intelligence gets the recognition it deserves. In a profession where we are wanting to heal and advocate, the foundation is being there for patients. When nurses are more in tune with their patients' feelings, they are able to anticipate needs, recognize patient cues, and see potential issues that can directly impact a patient's health.

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