The Nursing Department of New Hampshire Hospital, a large, university-affiliated state psychiatric facility, has a succinct mission statement: to care for patients using a process that demonstrates excellence in each nurse-patient interaction. Operationalizing this mission statement stimulated some challenging questions. What is the definition of excellence as it refers to nurse-patient interactions? Can excellence in nurse-patient interactions be measured by examining patient outcomes? Does our current nursing practice need to change in order to consistently achieve excellence? Attempts to answer these questions led to a firm commitment to the use of a particular nursing theory to guide our practice—that of Ida Jean Orlando.

This article describes the process used to make that commitment and tested its value through research. We hypothesized that Orlando Nursing Theory (ONT)-based practice, when compared with use of a non-specified nursing practice, would help RNs achieve more successful patient outcomes, namely, reduced patient distress levels.

The decision to use nursing theory to help define excellence in nurse-patient interactions was guided by nursing leaders within the facility who had worked in a theory-based nursing care environment. Once the decision was made to use a theory base to achieve our departmental vision, we convened a committee of RNs from both line and staff positions to conduct a rigorous review of nursing theories. After receiving the feedback of the entire nursing staff (registered nurses, licensed practical nurses, and mental health workers), the committee chose Ida Jean Orlando’s theory. Rationale for this choice include (a) the theory’s complementary relationship to the
vision of the department, (b) the theory’s clarity of purpose to assist the nurse in identifying and meeting the patient’s needs, (c) the theory’s emphasis on the interpersonal communication process, and (d) the relative simplicity of its language.

Our effort to define a product that was the outcome of excellence in each nurse-patient interaction was grounded in one of Orlando’s core beliefs: professional nursing is based upon an independent function resulting in its own unique product. Orlando (1987) notes that the “product of service should answer the question: what characterizes the behaviour of the person served after the professional function is carried out? (p. 410)”

It is Orlando’s (1961) premise that the product of good nursing is the reduction in the patient’s level of distress relative to that experienced prior to the nursing action. A patient’s behavior, which might consist of clenched jaws, wide eyes, and tensed body, is initial evidence to the nurse of the patient’s distress whether caused by pain, anger, anxiety, or some other source. The success of the nurse’s exploratory intervention depends upon the patient’s active involvement in determining both the cause of the distress and also an action which may reduce the distress.

**CONCEPTUAL FRAMEWORK**

Orlando (1961, 1972) contends that any “nursing situation” contains three elements. The elements are the behavior of the patient, the reaction of the patient’s behavior. Perceptions are the data that the nurse receives through the five senses, thoughts involve the nurse’s response to that sensory data, and feelings arise in response to those thoughts (Orlando, 1961, 1972). Orlando (1961, 1987) prescribes that the nurse perform a careful exploration of these perceptions, thoughts, and feelings in response to the patient’s behavior in order to accurately identify and meet the needs of the patient.

**NURSING THEORY:**

**A Pilot Study**

The nurse must acknowledge ownership of these perceptions, thoughts, and feelings as they are checked out with the patient. A key element of this process is the nurse’s understanding that one’s thoughts are not facts, and must be validated with the patient before being acted upon (Schmieding, 1984). The accuracy of the nurse’s reaction to the patient’s ‘data’ is validated before taking action to reduce the patient’s distress.

Jennings and Staggers (1998, p. 72)
believe that, "Outcomes are the end results of care; they help to illuminate successes and areas for improvement." Reid (1997) advocates clinical research that provides practitioners and he looks at the clock while waiting (perceptions).

The 'automatic' nurse thinks (as fact) that the patient will lose the extra cigarettes, because of his disorganization, and acts automatically. The nurse refuses the request, perhaps with reference to rules or a kindly lecture. "Sorry, I can only give you one. You won't have time to smoke them all before group, anyway."

The 'deliberative' nurse has the same perceptions and similar thoughts but is not sure they are accurate. The 'deliberative' nurse attempts to validate perceptions and thoughts before taking action to reduce the patient's distress. "Jim, your face is flushed; I'm wondering if you're anxious and want to smoke all of these cigarettes before group?" The patient's answer may or may not confirm the nurse's original thoughts. "No, I owe them to Fred. I wanted to give them to him before I went to group." The action taken to reduce the patient's distress in this example is also validated with the patient. "So, you'd like to have the cigarettes to give to Fred now?" "Yes." The patient is then observed to identify the product of the nursing action - reduced distress. "Jim, you've got a big smile on your face. Why is that?" Jim replies, "I don't like owing people things. Now I can pay Fred back the cigarettes I owe him."

IDENTIFYING NEEDS

Some patients cannot readily verbalize or identify their own needs for help. In caring for patients who experience severe cognitive or physical challenges, the nurse must depend on perceptions alone to validate needs. In these nursing situations, the nurse's observation skills are critical. Is the patient less restless, uncomfortable, or sad-looking after the nurse intervenes? Do these observations indicate that the patient seems less physically tense or more engaged? The ONT process remains an interpersonal one regardless of the patient's ability to respond verbally.

METHOD

In this study, the investigators examined whether ONT-based nursing practice had a measurable impact on patient outcomes. Patient outcomes resulting from use of ONT were compared with patient outcomes resulting from use of non-specified nursing interventions.

PROCEDURE

The investigators received approval for this quasi-experimental study from a review board at both the hospital and state levels. Registered nurses from all seven units within the hospital were interested in participating in the study. Because of limited financial resources and time constraints, the study was limited to two adjoining units.

The study units were selected after a review of staffing patterns, patient census, and relative acuity levels over the past several months. To ensure that the experimental and control groups of RNs and patients were similar, comparisons were done using t-tests or Yates-corrected Pearson's chi-square.

There were no significant differences in demographic composition between the experimental and control groups of RNs (Table 1). Patient scores on the Nurse's Observation Scale for Inpatient Evaluation (NOSIE-30; Honigfeld & Klet, 1965) were statistically comparable (Table 2). Designation as the experimental unit was based on the scheduling convenience of the units involved.

After obtaining informed consent all RN participants completed a demographic survey (age, sex, level of education, involvement in professional organizations, and participation in
TABLE 1.
BOCKENHAUER/POTTER SCALE OF IMMEDIATE DISTRESS (BPSID)

Assess the patient’s distress as you approached them at the beginning of your interaction.
(Circle one number which best describes the patient’s immediate level of distress. Examples of
descriptive behaviors are listed):

<table>
<thead>
<tr>
<th>Number</th>
<th>Behaviors</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td>No physiological or behavioral</td>
</tr>
<tr>
<td></td>
<td>(verbal/ nonverbal)</td>
</tr>
<tr>
<td></td>
<td>symptoms of distress</td>
</tr>
<tr>
<td>1</td>
<td>Pacing, sighing, fidgeting</td>
</tr>
<tr>
<td>2</td>
<td>Resistant to limits, somatic complaints,</td>
</tr>
<tr>
<td></td>
<td>trembling, shaking</td>
</tr>
<tr>
<td>3</td>
<td>Threatening to harm self or others,</td>
</tr>
<tr>
<td></td>
<td>yelling, crying, hyperventilation</td>
</tr>
<tr>
<td>4</td>
<td>Harming self or others, expressions of</td>
</tr>
<tr>
<td></td>
<td>hopelessness, panic</td>
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Please assess the patient’s distress as you left him/her at the end of your interaction.
(Please circle one number which best describes the patient’s immediate level of distress. Examples of
descriptive behaviors are listed):

<table>
<thead>
<tr>
<th>Number</th>
<th>Behaviors</th>
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<tbody>
<tr>
<td>0</td>
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<td></td>
<td>symptoms of distress</td>
</tr>
<tr>
<td>1</td>
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<td>2</td>
<td>Resistant to limits, somatic complaints,</td>
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<td>4</td>
<td>Harming self or others, expressions of</td>
</tr>
<tr>
<td></td>
<td>hopelessness, panic</td>
</tr>
</tbody>
</table>

continuing education) and orientation to the use of the Bockenauer-Potter Scale of Immediate Distress (BPSID)
which is used to measure patient distress. Participants on the experimental
unit also completed a one-hour introductory class on ONT. Each week of the
12-week study, RNs on both units chose one “nursing situation” (patient
behavior, nurse’s reaction, and nurse’s activity to reduce the patient’s
distress). They rated the patient’s levels of distress on the BPSID immediately
before and immediately after use of a verbal nurse-patient interaction as a
therapeutic intervention. Each intervention was prompted by a patient
behavior which appeared to reflect distress. Each intervention was designed
to reduce the patients distress.
The RNs on the experimental unit used an ONT-based intervention and documented their interaction on an
ONT process recording. They used their reaction to the patient’s behavior
to validate the presence of distress, the cause of distress, an action which
might reduce the distress, and an evaluation of whether or not the distress
was reduced. The RNs on the control unit used a nonspecified verbal nursing
intervention and documented the outcome in a narrative note. Each participat-
ing RN contributed one nurse-patient interaction per week to the
data collection.

During the 12-week data collection period, the study investigators met for-
formally with the RNs on the experimental unit to provide them a structured
opportunity to review assessments of the patient’s distress levels and patient
data, and to receive clinical supervision on use of theory-based interven-
tions. Meetings with the RNs on the control unit were sporadic and inform-
al with a focus on providing support to sustain interest in participation.
Numerical data were collected over the 12-week period and evaluated by
t-tests or Pearson’s chi square (Yates corrected for 2 x 2 table). The investi-
gators personally collected all data weekly. Subjective data were collected
and discussed during the group supervisory sessions but were not statisti-
cally analyzed.

SAMPLE
Ten RNs voluntarily participated in the study; 6 in the experimental group
and 4 in the control group. Mental health workers were not involved in the
initial pilot study but are currently involved in ONT education. One RN
on the control unit chose to withdraw from the study prior to its completion.
Thirty patients were involved in the study; 19 in the experimental group
and 11 in the control group.

RESEARCH INSTRUMENTS
Bockenauer/Potter Scale of Immediate Distress (BPSID) is a five-
point Likert-scaled instrument on
which the rater quantifies the degree of patient-demonstrated distress. Merwin and Mauck (1995) point out the need to determine ways to measure patient outcomes that result through the process of therapeutic relationships. Instruments designed to measure interventions must have content validity to ensure the computation of treatment effects rather than individual differences. Previously cited research described changes in both objective and subjective symptoms of distress as an effect of using ONT-based interventions. However, behavioral descriptions often lacked objectivity (Anderson, Mertz, &; Leonard, 1965).

To control for subjectivity, the investigators developed the BPSID. Using language from the Beck Depression Inventory (Beck, 1993), the State-Trait Anxiety Scale (Spielberger, 1968, 1984), and the Overt Agitation Severity Scale (Yudovsky et al., 1997), the investigators established behavioral anchor points to correlate with numerical ratings of distress (Figure 1). An expert panel consisting of the two investigators, an Orlando Nursing Theory consultant, and three hospital RN Nurse Specialists reviewed and refined the reference points on the scale. Interrater reliability was established through repeated evaluation of the same patients in videotaped simulated interactions using the tool.

### FINDINGS

Patients experienced a greater reduction ($P = .04$) in their level of immediate distress as measured by the BPSID when RNs used an ONT-based intervention, rather than a non-specified nursing intervention (Table 2). RNs using ONT were more consistently and significantly successful in meeting immediate patient needs. This resulted in lowering patient distress levels significantly more than when RNs used a non-specified nursing intervention. In describing their interactions, the nurses became more cognizant of the presence or absence of patient distress as a result of their interventions. Through use of validation, nurses were able to immediately confirm the outcomes of their nursing care.

As the study progressed, RNs on the experimental unit reported approach-
implementation of ONT is demonstrated in a nurse-patient interaction that took place on the experimental unit:

Pete was yelling in the unlocked time-out room. The nurse and two

mental health workers approached him. Pete yelled to the nurse, "You're burning! Your feet are on fire! You're a devil on fire!" She heard this comment and saw a wild-eyed young man. These perceptions stimulated some thoughts, one was that Pete was describing a frightening hallucination. She said, "You appear scared. Are you scared?" Pete continued looking about erratically and yelling about her being on fire, but did not answer her question. The nurse again tried to share her thoughts about her perceptions and asked for Pete's validation of an action that she had planned. She said, "Pete, you look anxious. Would you like some medication to help?" He did not answer. Instead, he took a cup of water and splashed her with it. The nurse's automatic response might have been to immediately withdraw.

In review, the nurse wished she had kept focus on her immediate reaction to the patient's throwing water and had stated, "I'm confused. I don't know why you are throwing water at me. Can you tell me?" Although understanding of ONT is relatively simple, application of the process is complex. The nurse was distracted by her previous thought that giving medication might help. She was not able to focus on the need demonstrated by Pete's throwing the water, but she did try to examine her thoughts carefully before taking action.

She realized that she did not think this behavior was threatening, nor did she feel frightened. She felt confused by the water-throwing behavior, but continued to address what she thought was the patient's need. At this point, it might have been helpful to validate Pete's perspective regarding his most immediate need. Everything Pete did and said made the nurse think, "He's anxious." She again offered the medication. Again, she was splashed. Pete's behavior seemed purposeful. It took one more splash before Pete accepted the medication. He was notably less upset within 20 minutes and able to go back to his own room.

Pete later sought out the nurse and thanked her for recognizing how anxious he had been. He explained that he had needed to put out her "flames" before he could get any help for himself. Of interest is the patient's awareness that his distress had decreased as a result of this nurse-patient interaction. He spoke to the treatment team and the hospital chaplain about how grateful he was for the understanding shown by this nurse.

NURSE ASSESSMENT OF PATIENT DISTRESS

While these investigators were able to demonstrate a significant effect of using ONT-based practice, no control was allowed for the potential "halo effect" of weekly education and support provided to the experimental unit. Our results were based solely on nurse assessments of patient distress. Interviewing patients about their response to these nursing interventions would provide valuable insights.
TABLE 3.

<table>
<thead>
<tr>
<th></th>
<th>Experimental n=19</th>
<th>Control n=11</th>
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<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>sd</td>
</tr>
<tr>
<td>BPSID</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>2.16</td>
<td>1.13</td>
</tr>
<tr>
<td>Post</td>
<td>.37</td>
<td>.60</td>
</tr>
<tr>
<td>Change Score</td>
<td>1.79</td>
<td>.92</td>
</tr>
</tbody>
</table>

One would expect patients to describe high levels of satisfaction with nursing care if the nurse-patient interaction had the effect of lowering their level of distress. It may also be possible to examine the long-term effects of ONT-based practice by examining patient surveys and recidivism rates.

**Does current practice need to change to achieve excellence?**

The initial answer would be yes, but nurses generally felt they already practiced within the parameters of ONT. Several nurses described ONT as "common sense" and "part of my basic nursing education." As noted, ONT was chosen because staff felt it fit with their current practice. However, nurses in the study reported and demonstrated how difficult it is to consistently keep the patient needs as the priority.

This focus requires that the nurse be fully and genuinely involved in the moment with the patient. The nurses noted that using "I statements" to demonstrate their ownership of their perceptions, thoughts, and feelings was challenging. However, they recognized them as "fact" (e.g., "I see you pacing. What's up?" rather than "You seem upset.")

Nurses appreciated the value of differentiating perceptions from thoughts and feelings when describing patient interactions. For many, the metaphor of a road map was helpful. The nurse needs to explore certain landmarks with the patient in order to arrive at the destination of reduced patient distress.

Since the adoption of ONT at our facility, nurses know how to identify and validate their perceptions, thoughts and feelings with patients before intervening. This action assures patient input is an integral part of the care plan. Furthermore, nursing administrators have identified the need to use this same process in their practice. This administrative modeling enhances use of theory-based clinical practice (Schmieding, 1991). Clinical supervision based on ONT is now planned for all nursing staff throughout the hospital.

**CONCLUSION**

In this study, we compared ONT-based practice with non-specified nursing practice. We hypothesized that ONT-based practice might help nurses achieve excellence in nurse-patient interactions which would lead to more consistently successful patient outcomes. Objective and subjective data confirmed this premise. Patients experienced a greater reduction (P = .04) in their level of immediate distress when ONT-based practice was used in comparison with non-specific nursing practice. RNs commented on a greater sense of purpose and direction in their approaches with patients. They felt they were closer to achieving excellence when using ONT.

This research invites further consideration of ONT. Patients' direct evaluations through patient satisfaction surveys might lend further support for use of this theory. Utilizing different measurement tools could provide a more extensive examination of patient outcomes. The effects of ONT on long-term outcomes, such as level of patient distress over time as well as recidivism rates, need to be explored. Furthermore, outcomes based on ONT need to be compared with those of other selected theories.

Walker and Avant (1995) advocate utilization and implementation of nursing theory to provide a clear defi-
nition of the role of the RN, a process by which to identify and meet patient’s immediate needs for help, and an affirmation of the value of nursing. Findings from this study affirmed the decision to use theory-based practice. The Nursing Department of New Hampshire Hospital chose Orlando’s definition for excellence in nurse-patient interactions. This definition was converted into a measurable patient outcome. Education and practice in Orlando’s Nursing Theory were found to help nurses achieve this outcome. In achieving this outcome, the nurses were better able to achieve their mission—excellence in each nurse-patient interaction.

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