Targeting the Affective Domain of Learning through Patient Stories, Leader-acted Skits, and Group Reflection to Embody the AIDET Model

Hannah Fogel[1], RN, BNSc, MN
Irene Zahrebelny, RN, MN, IIWC(C)
Alicia Lara Gonzalez, RN, BScN, MN
Maria De Leon, RN, BScN, MSN

PROBLEM

In complex continuing care and rehabilitation, establishing therapeutic relationships built on trust and respect is vital to patient care. However, in 2023/24 Q4, Long-Stay Resident Experience (LSRE) survey results revealed that dignity and respect metrics for Medically Complex patients and frequent visitors fell below the national average.

BACKGROUND

As our hospital is committed to a "customer service mindset", we introduced the AIDET communication framework (Acknowledge, Introduce, Duration, Explanation, and Thank You). AIDET helps reduce anxiety, improve perceived experience, and promote consistent, compassionate care (Studor Group, 2005).

The model had been introduced using didactic, cognitively focused teaching methods, but this approach failed to engage staff with its underlying value. Teaching from Bloom's (1964) *affective domain* – focused on values, attitudes, and feelings – was what was needed for embedding the principles behind AIDET.

METHODS

Real quotes from patient and family complaints were compiled into five-minute dramatized vignettes, performed during staff huddles by the Clinical Educator and Patient Care Manager. One portrayed the "patient" or "family member," and the other the "nurse," using costumes, props, and set pieces.

While viewing, staff were invited to write down any observed disrespectful behaviours on a board. A facilitated group reflection followed, encouraging discussion of alternative, more respectful approaches (Table 1). Through this process, participants organically re-discovered the AIDET model.

LITERATURE

Register et al. (2020) used role play with standardized patients to teach AIDET. In our version, unit leaders performed the vignettes, intentionally showing vulnerability to promote a "call-in" rather than "call-out" learning culture (Brown, 2015; Ross, 2019).

Humour was intentionally used to reduce anxiety, engage participants, and create a psychologically safe learning space (Smith & Noviello, 2012; Vanderheiden, 2024). By highlighting the humourous absurdity of some quotes, we fostered a non-shaming environment for reflection and growth.

Reflective practice is essential for professional development in nursing (Fowler, 2007; Kim, 1999). While mentors play a role in guiding reflection, peer feedback fosters accountability (Lillekroken et al., 2024)

References

Bloom, B.S. (1964). *Taxonomy of educational objectives: The classification of educational goals: Handbook II: Affective domain.* Longmans, Green and Co LTD.

Bloom, T. J. (2020). The importance of vulnerability in pharmacy educators. *American Journal of Pharmaceutical Education, 84*(7), ajpe7939.

Fowler, J. (2007). Experiential learning and its facilitation. *Nurse Education Today*, *28*(4), 427-433.

Kim, H. S. (1999). Critical reflective inquiry for knowledge development in nursing practice. *Journal of Advanced Nursing*, *29*(5), 1205-1212.

Lillekroken, D., Kvalvaag, H. M., Lindeflaten, K., Fløjo, T. N., Krogstad, K., & Hessevaagbakke, E. (2024). Educating the nurses of tomorrow: Exploring first-year nursing students' reflections on a one-week senior peer-mentor supervised inspiration practice in nursing homes. *BMC Nursing*, *23*(1), 132.

Register, S. J., Blanchard, E., Belle, A., Viles, A., Moore, S. P., MacLennan, P., & White, M. L. (2020). Using AIDET® education simulations to improve patient experience scores. *Clinical Simulation in Nursing*, *38*, 14-17.

Ross, L. J. (2019, Spring). *Speaking up without tearing down.* Learning for Justice, (61). Retrieved from: https://www.learningforjustice.org/magazine/spring-2019/speaking-up-without-tearing-down

Smith, C. M., & Noviello, S. R. (2012). Humor in the classroom using faculty skits. *Nurse Educator*, *37*(5), 198-201.

Studer Group. (2005). *AIDET®: Five fundamentals of patient communication.* Gulf Breeze, FL: Studer Group.

Vanderheiden, E. (2024). Humour in adult education. In *The Palgrave handbook of humour research* (pp. 521-556). Cham: Springer International Publishing.

Table 1: Patient/family perception and alternative

What did the nurse do wrong?	How could it have been done better?
No introduction, just walking in and started working	"Hi, my name is ____, I'll be your _____" Write name on the whiteboard
Speaking in another language after leaving the room; can feel isolating, disrespectful	Speak in English in public areas or while working
Started touching the patient without saying anything	Explain what you'll be doing, get consent
Removing sheets, using patronizing language like "pee-pee" and "poo-poo"	"Do you need changing?" "Bowel movement" "Number 1 or 2"
Yelling down the hallway about poo	Be mindful of who is in earshot
Terms of endearment, "mama", "my dear"	Use name or ask for permission
"Are you confused?"	Use evidence-based assessments
"I have 6 other patients"	"I haven't forgotten about you" Give a timeline/estimate
"That's not my job"	"I don't know how to do that, but I will ask ____ to help you"
"I can't, I'm busy"	Be realistic and accurate when telling them when you'll be able to help them
Wearing ear pods	Not while on the unit
Looking at phone while at the nursing station	Use computer for research Use phone on break

Figure 1: Participant reflections and call-ins

OUTCOMES

In Q1 of 2024/25, seven sessions were held with 95 staff members, including nurses, personal support workers, and allied health professionals. Sessions were characterized by joyful, engaged participation. Staff good-naturedly "called each other in" for observed practices and expressed admiration for ideas shared by their peers (Figure 1).

Prior to intervention, the LSRE metrics were more than 5% below the national average. By Q2 of 2024/25, those metrics had improved by over 5% from baseline. Additionally, other survey items related to dignity and respect – already at or above national benchmarks – showed further gains of more than 5% (Table 2).

Table 2: LSRE findings and comparison

Question	2021/22 National Research Corporation	Runnymede 2023/24 Q4	Runnymede 2024/25 Q2
Patients			
"Treated the way you want to be treated"	75%	67%	87%
"Have enough privacy"	73%	60%	67%
"Staff show you that they care about you"	68%	68%	87%
"Staff respect your wishes"	71%	74%	93%
"Staff try to understand what you're feeling"	60%	68%	85%
"Staff pay enough attention to you"	62%	72%	87%
Families			
"Staff's politeness and courtesy towards you"	94%	88%	94%
"Staff responding patiently to your questions and concerns"	83%	75%	89%
"Staff keeping you informed about your family member"	61%	63%	73%
"Rate your relationship with the staff"	N/A	82%	95%

KEY TAKEAWAYS AND NEXT STEPS

This educational restructuring reinforced that teaching values must engage the affective domain, not just the cognitive. Following the success of the sessions, the vignettes were adapted into short comparison videos illustrating "poor" versus "better" patient and family interactions. These videos are now embedded into standard orientation, with the same reflective facilitation approach – ensuring the method is both sustainable and scalable.

[1]Contact: Hannah Fogel, Clinical Educator | T: 416-762-7316 x2242 |
E: hannah.fogel@runnymedehc.ca | www.runnymedehc.ca

Scan here to view the vignette videos.