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UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Science

DOCTOR OF PHILOSOPHY IN NURSING

The Patient Experience as Rated By Consumers

by

Barbara Kelley

A dissertation presented to the

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DOCTOR OF PHILOSOPHY IN NURSING

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Dissertation Committee

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ABSTRACT

The purpose of this research project is to identify the key drivers in patients' satisfaction. Specifically, the factors that patients consider when assigning a numeric rating (0-10) to their overall hospital stay. The overall satisfaction question is significant because it is considered to be the "top box" question. The top box question is the patient-rated experience measure reported to Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in determining the compensation a facility receives for reimbursement in the Value Based Purchasing model. The results of this study have a financial implication for healthcare, as well as in the delivery of quality and compassionate care.

This qualitative study used semi-structured phone interviews to identify key factors participants considered when assigning the overall rating of their hospital stay. Data were analyzed using the following steps; immersion, *understanding, abstraction, synthesis and theme development, illumination and illustration of the phenomena, and integration and critique* (Ajjawi & Higgs, 2007). Ultimately the data were able to be consolidated into four major themes, 1) human interaction, 2) caring behaviors, 3) hospital accommodations and procedures, and 4) transition to home. The findings indicated patients most frequently placed the most significance on the human interactions and caring behaviors when asked about the influences on the overall hospital stay. The findings of this study are significant not only for those already in the healthcare field, but for academic institutions and curriculums, who struggle with finding the right person for the job. The results show us it is not only the academic knowledge that is important, but the human factor of caring and interpersonal skills that makes a qualified healthcare

provider. The results of the study, raises the question, “Is healthcare a profession or a calling?” Can compassion and empathy be taught and learned, or is it innate? All of these questions will need to be explored further in order to provide the care and compassion that is demanded from our consumers, the patients.

DEDICATION PAGE

I want to begin by recognizing and thanking my dissertation committee, Dr. Linda Urden, Dr. Cynthia Connelly, and Dr. Lori Burnell. First I would like to thank my chair Dr. Linda Urden for guiding me on this long journey, and understanding each time that “life” slowed me down. Dr. Cynthia Connelly helped to guide me down the path I am now ending, ensuring me from the beginning what I was capable of doing. Last but certainly not least, Dr. Lori Burnell, who gave me endless opportunities, guidance, and mentorship over the past 10 years. I was privileged to work for Lori, with her, and beside her, I am continually inspired by her professionally and spiritually each day. She has guided and supported me through many lessons that I will pass on to others, including the leap into leadership.

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I am thankful for the tolerance and forgiveness of my family, which cannot be captured in words. Carlos Jr, Brianna, Bianka, Cameron, and Addison. Each of you are forever my driving forces in making the world a better place for you all. Everything I do is with consideration of your futures in this world.

And to my husband, Carlos. Your never ending support of my innate ability to keep doing for everyone else, often foregoing those who need me the most. I love you and thank you for accepting my need to keep going and to keep giving.

“It’s not about how much you do, but how much love you put into what you do that counts.”

Mother Teresa

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Chapter 1

Historically patients sought essential care delivered by physicians and nurses in the hospital setting. This care was focused on meeting patients' physiological needs, often delivered in large open wards accommodating multiple patients. Physicians and nurses cared for patients absent formal processes or programs addressing their satisfaction. What was once a hospital stay, with care rendered in hopes of healing the disease or injury, has evolved into a hospital experience. What was the delivery of patient care is now known as the patient experience. Subsequently, patients' evaluation of the time they spent in the hospital has become more inclusive, encompassing the whole *patient experience*. Patient satisfaction and the patient experience have many interchangeable definitions; experience refers to the process of care, and is different than satisfaction which is a rating of experience (Edwards, Duff, & Walker, 2014). This evolving phenomenon has changed the traditional role of the patient to that of a customer; federal mandates have financial consequences for acute health care providers aimed at delivering the optimal patient experience. Technology has transformed patients into informed consumers capable of comparison-shopping for their optimal care experience.

The *patient experience* is at the forefront of healthcare today. Eighty-four percent of healthcare leaders have the patient experience among the top three priorities for their healthcare facility (Patient Experience & HCHAPS, 2013). The focus of this study will be on the patient experience.

Statement of the Problem

The Centers for Medicare and Medicaid Services (CMS) directs Value Based Purchasing (VBP), a program that ties hospital payments to performance, according to a set of quality measures (Chatterjee, Joynt, Orav, & Jha, 2012). The VBP program provides a CMS incentive for hospitals delivering high-quality care and is funded with monies withheld from previous Medicare reimbursements. In 2013, CMS withheld 1% of hospital reimbursements based upon CMS's diagnosis related group (DRG) rates to fund VBP incentives, an estimated \$850 million. Annually, the amount withheld from Medicare reimbursement is slated to increase by 0.25 percent per fiscal year until 2017, when a 2% withholding target has been achieved (Thompson, 2011). The financial impact for an individual hospital will depend upon the volume of Medicare patients served. Hospitals may potentially recoup this money based on their performance in core measures established by CMS. These core measures include specific, quantitative measurements in specific disease processes – acute myocardial infarction, heart failure, pneumonia, health-care-associated infections, and surgeries. The only non-physiological-related measure is the patient's rating of the hospital experience. Each CMS initiative has a quantitative measurement, an achievement threshold, and a benchmark. The benchmark for each measure is determined by the mean performance of the top 10 percent of the hospitals nationwide. Several factors are combined to calculate the amount

of reimbursement based on the achievement or improvement scoring for each measure, as well as consistency in scoring for measures within the patient experience (Berger, 2011). Literature is replete on Value Based Purchasing and financial implications associated with this program; unfortunately, there is a notable absence of research describing what constitutes the ultimate high scoring experience from the patients' perspectives.

Background

In 2002, patient satisfaction was defined as “the patients’ subjective evaluation of his/her cognitive and emotional reactions as a result of interaction between their expectations regarding ideal nursing care and their perceptions of the actual nursing care” (Johansson, Oleni, & Fridlund, 2002, p. 337). Patient satisfaction and the delivery of quality care are not new concepts to healthcare. Patient satisfaction scores have been a routine topic discussed at board meetings and amongst leaders during annual performance reviews. Nevertheless, measurement specifics related to patient satisfaction have remained dormant, embedded within the quality departments of many hospitals, a far distance away from those closest to the patient.

Programs designed to improve patient satisfaction have gained immense momentum and interest since the Value Based Purchasing became part of acute care hospitals’ reimbursement reality. Federal government initiatives have created a flurry of activity throughout the nation, especially in health care facilities. On October 1, 2012, the definition and measurement of patient satisfaction was broadened beyond Johansson’s (2002) definition to include a means of reimbursement for acute care hospitals. The Patient Protection and Affordable Care Act (ACA), a VBP program, was signed into law in March 2010 (House Resolution 3590, 2009). This law incentivizes hospitals to pursue

and improve patient satisfaction (Thompson, 2011). The ACA alters reimbursement and redirects the focus for acute hospitals across the nation by reckoning Medicare reimbursement to 13 core measures of care performance. These core measures include acute myocardial infarction, heart failure, pneumonia, nosocomial infections, and surgery outcomes (Shoemaker, 2011).

Currently, 28 measures are voluntarily reported by hospitals to the Hospital Quality Alliance (HQA), a public-private group established to promote transparency related to the quality of health care delivery. A second factor influencing reimbursement is patient satisfaction, a patient-rated experience measure as reported on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey designed by CMS. Patients are selected to receive HCAHPS surveys after an inpatient stay. Hospitals use the HCAHPS survey and contract with a third party administrator to correlate and report survey results. The results of the 28 measures are publicly reported, and also provide the basis for Medicare reimbursement under the VBP. The results of these objective and subjective measures are more significant than ever to hospitals.

Problem Statement

Patient satisfaction has transformed from a *nice to have* hospital accomplishment to an essential means of recouping reimbursement that aligns with federal regulations and quality outcome requirements. A notable absence of research describing the factors patients' consider when assigning the numerical value to their overall patient experience during their hospital stay, was discussed in a comprehensive literature search. However patient satisfaction has a huge impact on many factors. A 2012 study showed the level of a patient's satisfaction with his/her health care experience has been positively correlated

to the patient's compliance with treatment and health care outcomes. High patient satisfaction has been equated to patient loyalty and positive word-of-mouth advertising. Conversely, unfavorable or poor self-reported patient experiences have been associated with slower recovery and decreased likelihood of adherence to prescribed treatment regimens (Chatterjee et al., 2012). Another study reported caregivers working within a system delivering optimal customer satisfaction experiences filed fewer malpractice suits (Welch, 2012). Healthcare providers must understand and appreciate the patients' perspectives and perceptions of their patient experiences in order to provide the most reimbursable patient care. The patients' perspective of their overall hospital experience is subjective and individually interpreted by each patient and family. However by identifying key factors influencing the patients' perspectives, healthcare providers are able to meet and exceed patients' expectations.

Purpose of the Study

The purpose of this study was to explore the patient experience from the patient's perspective and to identify key drivers influencing patients' ratings of their overall hospital experience reflected on the HCAHPS survey. Utilizing a phenomenological approach, telephone interviews were conducted with patients post-discharge from an acute care facility.

Research Question

The research was designed to examine the contextual factors that influenced a patient's overall rating of his/her hospital stay when completing the Press Ganey HCAHPS survey post discharge.

Therefore, the following questions were posed:

- Do you recall receiving the HCAHPS survey after your inpatient hospital stay?
- Do you remember the question asking, “Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?”.
- Can you remember and tell me some of the events or conditions that influenced what number you gave the hospital on this question?
- Were there specific incidents or events that you recalled when answering the question?
- Can you think of anything else you would like to discuss in regards to your patient experience?

Aims

The overall goal of this study was to explore the hospital experience from the patient’s perspective and to identify key drivers that influence a patient’s rating of his/her overall hospital experience on the HCHAPS survey. An underlying assumption of the researcher was the nurse has the greatest influence on patient satisfaction, and one negative interaction will prevent the patient from rating the experience a 9 or 10 score.

The specific aims of this study were to:

1. Gain a broader understanding of the patient’s experience from the patient’s perspective.
2. Identify key drivers that influence a patient’s rating of his/her overall hospital experience on the HCAHPS survey.

Methods

This qualitative study employed an interpretive phenomenological methodology to identify the contextual factors that influenced the patient's overall rating of the hospital on the Press Ganey HCAHPS survey, post discharge. The researcher selected a qualitative approach because of the lack of previous research in regards to the factors influencing the patient's rating of hospitals on the HCAHPS survey. There were no previous studies found specific to the patient's rating on the survey regarding their overall stay. This made it evident to the researcher the need to explore and understand this phenomenon. By instituting an interpretive phenomenological approach, the researcher could explore a deeper understanding of the phenomenon of the patient experience through the lived experience of the participants (Creswell, 2007). Benner (1994) notes interpretive phenomenology involves meticulous analysis of the study participants' experiences through narrative accounts of their narrative lived experience.

Assumptions

A number of assumptions are inherent to interpretive phenomenology. First, participants are knowledgeable about the topic, honest, and do not intentionally conceal aspects of their experience (Holloway & Wheeler, 2002). Thus to better understand the patient experience and how the patients score the overall rating of the hospital on the HCAHPS survey, it is essential to study the lived experience of the patients who have had a hospital stay and have completed a HCAHPS survey. The researcher asked open-ended questions to facilitate dialogue with the participants of the study and to evoke their patient experience and evaluation of the hospital stay.

Conceptual Underpinnings

The evolution of the patient to a client or customer has made health care into a highly competitive business. Patients *now* expect high-quality and technically advanced healthcare from every institution in the world. This transformation is placing a greater emphasis on the interpersonal care provided by nurses, physicians, and ancillary staff during their hospitalization. In 2002, Johansson, Oleni, and Fridlund defined nursing care as:

(T)o promote health and to help, support, educate, and develop the patient by liberating his or her own resources. Nursing care is based on interaction and participation for the purpose of satisfying universal and personal needs in relation to daily life, needs that have become disrupted because of ill health. Professional nursing care is based on theoretical knowledge and systematic scientific methods.

In the midst of the need to emphasize interpersonal care, hospitals are facing escalating costs in providing care. This is coupled with decreases in reimbursement, as well as higher quality standards which are tied to hospital reimbursement. The natural progression of the increased cost of care and the decrease in reimbursement results in hospitals being forced to cut costs, which ultimately effects the staff.

The patient's subjective perception of his/her patient experience, or patient satisfaction, is gaining great importance. Indeed, patient satisfaction has become synonymous with nursing quality of care and a primary indicator of quality (Johansson et al., 2002).

Significance/Implications

Findings from this study will benefit patients by providing information to health care providers in accordance to the patient's expectations for their hospital experience. Physicians, nurses, ancillary staff, as well as hospital administrators will gain a better understanding of what is important to the patient from the patients, verses what these individuals think is important to the patient.

Prior studies reveal what patients feel is important is significantly different than what nurses think is important to patients (Lynn & McMillen, 1999). The patient's perspective is imperative in delivering quality care, not only in the delivery of that care, but in meeting the patient's expectations of his/her quality of care. Although it is vital for organizations to continue to strive in the delivery of quality care, it is also critical that consumer's needs are incorporated into hospital routines. As hospitals meet and ultimately exceed their consumers' expectations, the overall patient experiences should be satisfying to the patients.

Summary

The HCHAPS survey is designed for acute care hospitals reimbursed under the Inpatient Prospective Payment System (IPPS). These hospitals are eligible for annual payment updates and required to participate in HCAHPS reporting. The federal government has tied the future of healthcare closely with patient (customer) satisfaction. The identification of key elements in the patient experience may further guide acute care hospitals in their efforts towards determining specific education, behaviors, and characteristics needed within their environment. This study examined the different influences on the patient scoring of their overall patient experience. This study examined

the different influences on the patient scoring of the overall patient experience, and identified the practices that create a positive patient experience that maximizes CMS reimbursement for a facility. Technology has transformed patients into informed consumers capable of comparison-shopping for their optimal care experience. Hospitals must continually improve their clinical measures, as well as exceed patients' expectations.

Chapter 2

The patient experience of care is measured by utilizing a random sample of patients discharged from hospitals across the country and asking questions about their feelings and perceptions relative to their hospital stay. The necessity to dissect the patient's perceptions and influences in scoring this question is imperative in aligning efforts to build an environment and culture of care delivery around promoting a positive patient rated experience. This literature review explores and defines the concepts of patient satisfaction within the V model and the significance to today's healthcare environment. It also serves as a historical perspective of the legislative actions that underpin the current health care situation. The researcher discussed the determinants for reimbursement in the VBP model specific to the HCAHPS survey. The HCAHPS survey is designed for acute care hospitals. Any hospital reimbursed under the IPPS eligible for annual payment updates are required to participate in HCAHPS reporting.

An extensive literature review revealed an abundance of research related to patient satisfaction. However, there was a deficiency of studies addressing the patient perspective on the overall rating of the hospital or they determined the rating score. The specific question on the HCAHPS survey asks; "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you

use to rate this hospital during your stay?” (Studer, Robinson, & Cook, 2010, p. 269).

This question is salient as it encompasses every aspect of the patient’s stay. From a financial standpoint, it is one of the factors in determining the amount of reimbursement facilities will receive in the VBP model. Studer et al. (2010), reported nursing interventions most highly correlated with this question were nurse communication, pain management, and responsiveness of staff.

Patient Satisfaction/Patient Experience

Patient satisfaction has been defined as the patient’s subjective evaluation of their cognitive and emotional reactions reflecting interactions between their expectations of ideal nursing care and their perceptions of the actual nursing care (Johansson et al., 2002). Satisfaction included cognitive evaluation, emotional reaction to the components of care delivery, and service. Satisfaction is an individually subjective perception that is tied to one’s expectations regarding his/her care and service. When an expectation was not met, the result was a sense of decreased satisfaction. Many issues have been identified in measuring patient satisfaction including validity and reliability, methodology, survey design, survey administration techniques, and timing (Shoemaker, 2011).

Value-based Purchasing (VBP)

Value-based purchasing is defined as a payment methodology that rewards quality of care through payment incentives and transparency in healthcare. The VBP is not a new concept; however, the program is new to many in healthcare, particularly those practicing at the bedside. The VBP initiative has been evolving within government bodies for over a decade. Nevertheless, it was only recently, with the support of

President Obama, this program was placed in an actionable state. Value-based purchasing is a payment methodology that rewards quality of care through payment incentives and transparency in health care (Joynt & Rosenthal, 2012). The program considers core clinical and patient satisfaction measures, each weighted, and combined into one composite VBP score for every hospital, thereby determining total reimbursement. The average hospital payer mix for Medicare is 40%, with 5% beneficiaries participating in the fee-for-service payment model. This initiative is expected to reduce Medicare spending by approximately \$214 billion over the next 10 years (Shoemaker, 2011).

Historical Overview

The history behind the VBP initiative commenced in 2003 when the Medicare Modernization Act (MMA) presented by Congress, commissioned the Institute of Medicine to identify and prioritize options to align performance to payment in Medicare. The Deficit Reduction Act (DRA) of December 2005, introduced language from the Secretary of Health and Human Services that expanded hospital quality measures. These included additional clinical measures, as well as patient perspective measures. All would have an impact on a facility's ability to receive full market reimbursement. The DRA required the U.S. Department of Health and Human Services (HHS) to develop a VBP implementation plan to receive Medicare payments beginning fiscal year 2009.

In August 2006, proposals for the outpatient prospective payment system included two links to HCAHPS. First, outpatient payment updates were linked to participation in submission of current inpatient quality metrics. Second, HCAHPS was required as an inpatient quality metric for inpatient and outpatient payment updates for the fiscal year

2008. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 required the HHS to develop a VBP transition plan for all providers receiving Medicare payments. This new program changed Medicare reimbursement for 3,500 hospitals across the country. Under the IPPS for fiscal year 2008, inpatient metrics were expanded to include HCAHPS reporting. In order for hospitals to receive the full market update, they were required to submit HCAHPS data beginning July 2007.

The Patient Protection and Affordable Care Act was signed into law March 2012. The Secretary of Health and Human Services then mandated the VBP program be operational (Borden & Blustein, 2012). Subsequently, President Obama authorized VBP with the Affordable Care Act, effective fiscal year 2013. The plan helps to support the goals of the Partnership for Patients, a public-private initiative launched by the Obama administration on April 12, 2013. The two goals of the Partnership for Patients were to: (a) decrease hospital readmissions by 20 percent, and (b) reduce preventable hospital-acquired conditions by 40% in the first four years of the program. The program transitions payments to acute care hospitals from a volume based model to one that rewards hospitals for the quality of care they delivered. Hospitals will receive a monetary reward based on both achievement and improvement in the delivery of high-quality care (Borden & Blustein, 2012).

The VBP program payment system empowers CMS to withhold a portion of a hospital's Medicare reimbursement and then return it if the facility exceeds the average performance of other hospitals across the nation. The initial cut is a 1% decrease to Medicare's diagnosis-related groups (DRG) payment rates, which will increase by 0.25% per year up until fiscal year 2017 when it will cap at 2% (Werner & Dudley, 2013).

Hospitals may potentially earn back the reimbursement withheld, based on their ability to exceed the average performance of other hospitals on core measures established by CMS. The amount of financial impact for a hospital will depend on its caseload of Medicare-covered inpatients.

Measurement Specifics

The VBP program considers core clinical and patient satisfaction measures and weighs them, then combines them into one composite VBP score for each hospital. Core measures include specific quantitative measurement in specific disease process, along with a metric related to the patient experience (i.e., patient satisfaction scores). There were 13 measures for the inpatient VBP program for October 2011 through September 2012. The measures included specific processes related to acute myocardial infarction, heart failure, pneumonia, health-care associated infections, surgeries, and the overall patient-rated experience. Each initiative has a quantitative measurement along with achievement threshold and a national benchmark. The benchmark for each measure is the mean performance of the top 10% of the national hospitals measured in that particular domain. The basis for the patient-rated experience measure in the VBP program is the HCAHPS (Press & Fullam, 2011). The survey is comprised of standardized questions that measure satisfaction of the patient experience during hospitalization.

The VBP model takes core clinical and patient satisfaction measures weighed and combined into one composite score for each hospital (Keckley, Coughlin, & Gupta, 2011). The total VBP score for a hospital will be based on its achievement or improvement score for each measure of the clinical process of care and achievement or improvement for each dimension in the measure of the patient-rated experience of care,

as well as the consistency score on the patient experience measure (Kurtzman, Dawson, & Johnson, 2008). Value-based purchasing has created an increasing interest in the drivers of patient satisfaction and global satisfaction with hospital quality and care delivery.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

The HCHAPS survey is designed for acute care hospitals; any hospital reimbursed under the IPPS and eligible for annual payment updates is required to participate in HCAHPS reporting. Although the basis for VBP includes several quantitative measures within specific medical diagnosis, there is also the subjective measure of the patient experience. By the year 2017, CMS will be withholding 2% of Medicare reimbursement for each hospital, which will equate to potentially millions of dollars for facilities depending on the percentage of Medicare patients served. The scoring of the patient experience factor is based on the HCAHPS survey.

The patient-rated experience in VBP program is measured with HCAHPS. The HCAHPS provides a standardized reporting metric for the public with respect to the patient experience; for quality improvement and monitoring activities, additional measurements are required.

HCAHPS History

The HCAHPS survey was the first national, standardized, and publically reported survey of the patients' perspective of their patient experience. The survey was developed in 2002, when CMS partnered with the Agency for Healthcare Research and Quality (AHRQ) to create a means of nationally standardizing, collecting, and reporting the

patient experience. The survey's creation and ongoing development was initially founded on three goals:

1. To produce data on the patient perspective of their care that would allow for objective and meaningful comparisons of hospitals. The data would allow consumers to objectively compare hospitals on topics that were important to them.
2. To publicly report the survey. The publicly reported HCAHPS was designed to create a sense of competitiveness in the healthcare setting. This environment of competition would drive incentives to improve the quality of care providers delivered.
3. To provide transparency to the public related to the quality of care delivered in the facility. Hospitals had the potential to increase their accountability to the quality of care they deliver, in return for the public's support as a customer.

Press (2005) noted: "As the patient becomes more of a consumer, patient satisfaction becomes increasingly relevant as a key indicator of how...care is actually experienced by patients. Given that cure itself cannot be guaranteed, this personal experience of care-defined and measures as satisfaction-is a (reasonable) indicator of how well the hospital expresses its core mission. Satisfied patients mean higher quality care" (Press, 2005, p. 115). The HCAHPS survey's validity and reliability was supported through focus groups, pilot tests, survey administrations, and client feedback.

The National Quality Forum, a national organization comprises healthcare providers, consumer groups, federal agencies, purchasers, research and quality organizations, and professional associations, endorsed HCAHPS in May 2005 (Department of Health and Human Services, n.d.). HCAHPS received its final

endorsement in December 2005 from the federal Office of Management and Budget. Then in October 2006, CMS implemented HCAHPS nationally and in March 2008, the first public reporting occurred.

Survey content. The survey consists of standardized questions that measure satisfaction in a given context. Additional questions may be added to the survey by individual organizations. The survey is designed for adult patients discharged from general acute-care hospitals who have experienced an overnight stay as an inpatient. Press Ganey exclusion criteria comprises patients less than 18 years of age, those who died in the hospital, patients discharged to hospice, patients who received psychiatric or rehabilitative services, prisoners, and any person with an international address. The HCAHPS measures the patient experience of care during the hospitalization with eight domains. The reimbursement within the VBP program is based on an aggregated score for the domains. Domains included nurse communication, physician communication, the hospital environment, responsiveness of hospital staff, pain management, communication about medications, discharge information, and overall rating (Bombard, 2011). The survey comprises 27 standard questions. There are 18 questions that evaluate patient care, 16 of these are asked as frequency questions (i.e., never, sometimes, usually, always, or yes/no). Two questions represent a global rating, one on a scale from 0-10 for the overall experience and the other on the likelihood of recommending the hospital on a four-point scale from *definitely no* to *definitely yes*. There are four screening questions and five demographic questions about the patient. Within each domain, two to three questions are used to capture a domain score. How a patient responds to the HCAHPS

overall rating question, “rate this hospital during your stay” from 0-10, determines the amount of reimbursement provided to that facility (Studer et al., 2010).

Requirements. All general and acute care hospitals reimbursed under the IPPS and eligible for annual payment updates must participate in HCAHPS. Those excluded are specialty facilities such as pediatric, psychiatric, rehab, cardiac, oncology, orthopedic, and long-term acute care hospitals (LTACH). The hospital is identified based on its Medical Provider number(s). If two hospitals share a Medicare provider number, a request can be made to CMS for a unique identifier for the HCAHPS process instead of sharing the same identifier. HCAHPS surveys may be integrated with other surveys; however, the HCAHPS core questions must be placed at the beginning of the survey in the specified order. The Centers for Medicare and Medicaid Services will provide the surveys in English, Spanish, Vietnamese, Chinese, and Russian. A cover letter must be sent with each survey. All HCAHPS surveys must be sent between 48 hours and six weeks after the patient is discharged from the facility. There are several options for distribution of the surveys. First, there is a two-wave mail distribution or a five-phone call attempt to distribute. Hospitals may combine the mail and phone call method – first mail the survey and then attempt up to five phone calls. The final option is an Interactive Voice Response (IVR); a live person calls the patient and asks them to complete the survey by phone while listening to a computerized survey (Department of Health & Human Services, n.d.).

Hospitals are required to conduct the random sample at least once a month and submit a minimum of 300 completed surveys over 12 months for data to be publicly reported. Smaller hospitals that do not have enough eligible discharges to achieve 300

surveys returned or have fewer than 900 discharges a year, should target at least 100 surveys per year. The surveys must be distributed throughout the entire collection period, even if the minimum requirement has been achieved prior to the annual date.

The data is submitted to Quality Net (QNet) where the information is housed for CMS. The data is adjusted based on patient characteristics including type of service, age, education, self-reported health, and language spoken at home. Adjustments are also made for the mode of survey distribution, volume fluctuations, and the possibly of non-response bias.

Patient mix adjustment is a calculation used to adjust a hospital's results based on patient and hospital demographics to reflect a *typical* patient population. The intent of patient mix adjustments is to make data comparable across different settings; CMS will apply patient mix adjustments to a hospital's data before it is publicly reported (Department of Health and Human Services, n.d.). The HCAHPS survey is in the public domain and can be extended to anyone independent of the HCAHPS initiative.

HCAHPS Timeline

Press Ganey conducted a feasibility study prior to national implementation of the HCAHPS survey in April, May, and June 2006. The surveys were submitted to CMS, but not publicly reported. National implementation began in October 2006 for voluntary data collection. In late 2007 and early 2008, HCAHPS first publicly reported hospital performance on the California Healthcare Foundation website (California Healthcare Foundation, 2012).

Survey Issues

Response rates. There were many issues associated with a lack of conceptual and methodological rigor related to satisfaction studies as a whole. Specifically, *inpatient* satisfaction researchers appeared willing to accept relatively low response rates as both legitimate and inevitable. Notably, response rates as low as 30% have been proposed as *reasonable* for patient satisfaction surveys, while 50% have been considered *quite high*, and 80% *very high* or *remarkable* (Sitzia & Wood, 1998).

Scoring subjectivity. Since the beginning of patient satisfaction scoring techniques in the 1980s, much controversy has surrounded patients' ability to be a valid judge of quality of care. Most agree patients should have a voice in defining and developing the patient experience; however, necessary response rates remain a controversial topic.

Additional issues have been identified with the linkage between outcomes and patient satisfaction. One area of contention is the length and numbers of treatments patients require before they are *cured*; patients may receive and complete their surveys prior to completing treatment and be satisfied with their outcome. Another point of concern is even after receiving high quality and appropriate treatment, patients may still experience discomfort, weakness, and/or pain that may also be reflected on their surveys (Press & Fullam, 2011). Patients were concerned with what they believed was appropriate and quality care, at times incongruent with how clinicians were evaluated on quality care measurements. In the VBP model, hospital administrators must align these stakeholders to meet patients' expectations for their experience. Press and Fullam (2011) noted, "to suggest that patient satisfaction is irrelevant to the 'real' quality of care

is like saying that the food at a restaurant is highly nutritious and prepared with top quality ingredients—yet tastes lousy” (p. 112).

Concerns associated with the relationship between satisfaction and quality were one of the countless issues regarding the new power given to patients. Another issue was the amount of influence patient satisfaction had on providers’ treatment decisions. The financial pressures of performance measures in satisfaction, specifically reflective of clinicians, has had an impact on decisions that otherwise have been made solely by the physicians based on patient symptomology and diagnoses. Patients’ demands on service including inappropriate tests, excessive pain control measures, and extended length of stays have all created points of controversy regarding the value being placed on patient satisfaction. The value of patient satisfaction, according to the IPPS, is 30% of the withheld percentage (up to 2%) of Medicare reimbursement for each institution (Press & Fullam, 2011).

Another variable found to have significance on the patient’s satisfaction scoring is the timing of completion of the survey. In 2008, CMS’s Mode Experiment found a variation in patient’s evaluation based on the response order, or “relative lag time.” The “relative lag time” is the time from when the patient is discharged to the time the survey is completed. The study found the longer the lag time the less positive the responses are when compared to early responders. There is also a recommendation to conduct interviews within two weeks post patient discharge. This reduces recall inaccuracies and bias (Holzer & Minder, 2011). In addition, the patients’ perceptions of their experiences change over time and are impacted by outcomes.

Demographic variability. Analyses of HCAHPS surveys found respondents generally expressed disfavor of organizations with certain characteristics, such as large, academic hospitals in northern regions of the country that treat large numbers of patients with either depression or complex and serious illnesses. The unfavorable scores were reported irrespective of the high quality clinical care outcomes achieved at these institutions. One study, completed by Cleveland Clinic, found there were no hospitals in the nation having 500 or more beds that scored in the 90th percentile or higher in physician or nurse communication (Daly, 2011). Daly suggested HCAHPS scoring should identify regional disparities and indicated small community-based hospitals in the Southeast performed best on the surveys, while those in the Northeastern states scored lower. The American Hospital Association reported teaching hospitals that performed poorly on patient satisfaction tended to receive higher scores on process-of-care measures than non-teaching hospitals. Daly described another potential complication of the patient satisfaction survey was high marks for perceptions of care that had little connection to high quality clinical outcomes. *USA Today* conducted and published an analysis of Medicare patient-satisfaction survey data and mortality statistics, which found hospitals with the highest patient rankings also had high death rates (Daly, 2011).

A 2012 European study administered the Caring Behaviors Inventory (CBI) on a convenience sample of patients and nurses examining caring behaviors. The study used a multiple stepwise regression using patients' personal characteristics as independent variables and found the strongest predictors affecting the total CBI were the type of admission, age and perceived health condition (Patiraki et al., 2014). The study finds older patients are more positive in their evaluations of nurse caring behaviors.

Contextual variables. A 2010 study was designed to identify relationships between general practice population variables and patient experience scores as identified on the MORI Primary Care survey. Although weak in correlational strength ($r = -0.28$, $p = 0.006$), the study did demonstrate a statistically significant, inverse correlation with deprivation (Gray, Richmond, & Ebbage, 2010), thus supporting the theory patients seen in more deprived areas reported lower satisfaction with the care they received. While the study was conducted in a general practice setting, the findings were significant to patient satisfaction surveys in general related to populations served.

Patient Experience and Clinical Outcomes

Patient satisfaction is significant beyond its tie to VBP reimbursement. Although VBP directly connects patient satisfaction scores to monetary reimbursement, there are other indirect effects of a positive experience. Studies have demonstrated the correlation between patients' satisfaction with their healthcare experience and their compliance with treatment/healthcare outcomes (Chatterjee et al., 2012). Patient evaluations of their hospital experience are utilized to improve the quality of care delivery. High patient satisfaction equates to patient loyalty and positive word of mouth advertising. In contrast, poor self-reported experiences with health care systems have been associated with slower recovery and a lower likelihood of adherence to prescribed treatment regimens (Chatterjee et al., 2012).

Several factors can mitigate the satisfaction a patient reports, such as the socioeconomic setting of the neighborhood and where he/she received his/her care. One study suggested patients living in rural areas report better care than those living in urban areas (Levinton, Veillard, Slutsky, & Brown, 2011).

Nursing engagement. An engaged workforce has positive and productive outcomes for multiple stakeholders. A 1990 study by Kahn found engaged employees had higher customer satisfaction, productivity, and profitability. Organizations with higher employee engagement demonstrated better employee retention and improved customer satisfaction (Rivera, Fitzpatrick, & Boyle, 2011). Ankner, Coughlin, and Holman (2010) reported hospitals with higher nurse engagement had a statistically lower mortality index, complication index, and a positive impact on nursing sensitive indicators. The study concluded the key to delivering high quality, cost effective care was an engaged workforce. In 2009, Press-Ganey noted a hospital's top five priorities must include focusing on empowering staff to "effectively communicate information and empathy to their patients" (Lauer & Beryl Institute, 2009, p. 4). Kahn's study suggested effectively engaged employees had a strong positive influence on a hospital's service climate. The same study found the engaged employee also positively impacted customer satisfaction resulting in higher productivity and profitability (Kahn, 1990). According to Rivera et al. (2011), organizations with higher employee engagement demonstrated better employee retention and improved customer satisfaction.

Nursing certification has also been linked to impacting patient satisfaction scores. Attainment of professional specialty certification positively impacts the care delivered by the nurse. The American Nurses Association began certifying nurses in the 1970s for professional acknowledgement. Certification confirmed a nurse's achievement in a specific, specialty-related body of knowledge (Callicutt, Norman, Nichols, Smith, & Kring, 2011). A study by Cary (2001) linked higher nursing certification with lower patient mortalities and higher patient satisfaction scores. Nursing certification has been a

required benchmark of Magnet hospitals; however in 2009, the mean certification rate reported at the ANCC National Magnet Conference was only 27.6%. A poll conducted by the American Association of Critical-Care Nurses found 78% of consumers knew about nursing certification and 73% stated they prefer a hospital that employed certified nurses (Callicutt et al., 2011).

The Nursing Executive Center (NEC) described an engaged nurse as one who “should be inspired by his/her hospital, willing to invest discretionary effort, likely to recommend employer, and planning to remain with the hospital for the foreseeable future” (Rivera et al., 2011, p. 265). Hospitals with high employee engagement have many positive benefits including; better employee retention, improved customer satisfaction, and overall business success. When the NEC surveyed over 4,000 hospital-based nurses in the United States, findings indicated only 26% were engaged. Kahn (1990) asserted effectively engaged employees had a strong positive correlation to a hospital service climate and the engaged employee has a more positive influence on customer satisfaction with higher productivity and profit.

Work Environment

Analysis of the study findings reveals nurses’ attitudes, actions, as well as their interactions with patients, physicians, and other staff members, have a major influence on the patients level of satisfaction during their stay. In order to better understand the contextual factors that might influence the nurses’ attitudes, actions, and interactions with others, there must be an understanding of the complexity of their work environment.

A study completed in 2003 examined the acute care environment to better understand the complexity of the nurses’ work. The study addressed the following;

issues affecting nurses' work, cognitive factors driving nurse performance, decision making, and strategies used to manage work successfully (Ebright, Patterson, Chalko, & Render, 2003). The data revealed an array of factors that were categorized in 22 different themes that reflected work complexity, cognitive issues driving work performance and decision making, and strategies for care management. When reviewing factors the study themed with work complexity, some of the specific issues included; disjointed supply sources, missing equipment or supplies, repetitive travel, multiple interruptions, waiting for symptoms or processes, difficulty assessing resources to continue or complete care, inconsistencies in care communication across the care providers and/or patient, and breakdown in communication. This study supported what was found in the Ebright et al., study of 2003. The data supported patients reported being very pleased when there was a positive relationship between the physician and the staff. A participant referred to the staff as "Dr. S's staff on her two floors, are right on top of it." The participant viewed the floor and the physician as an aligned team, with the physician as the leader. This participant described a positive experience with both the staff and the physician, and ultimately the patient experience. However there was much dissatisfaction when the communication was broken or not clear between the care team. One patient recalled, "There was a huge disconnect between the right physician to call."

The cognitive issues directing the nurses' activities were determined to be goal patterns and knowledge patterns. Themes such as maintaining patient safety, preventing from getting behind, avoid increasing complexity of situations, appearing competent and efficient to coworkers, and maintaining patient/family satisfactions were considered goal patterns (Ebright et al., 2003). These findings support a variety of the key drivers

identified by the participants in the study as distinguishing the factors contributing to the complexity of the nurses' work environment.

Nurses working in a professional practice environment and engaged in their practice have higher customer satisfaction, productivity, and profitability (Calicut et al., 2011). Five elements portray the professional practice environment; adequate staffing, strong nursing leadership, staff decision involvement, a nursing model of care, and effective nurse-physician collaboration (Seymour & Dupree, 2008). The results of this study, specifically the interviewees in referencing to the nurse-physician relationship, support the finding of Calicut, et al., in 2011. Another study suggested an effectively engaged employee has a more positive influence on customer satisfaction with higher productivity and profit (Kahn, 1990). Organizations with higher employee engagement demonstrated better employee retention and improved customer satisfaction (Rivera, et al., 2011).

Cognitive Works of Nursing

There have been several studies examining the cognitive work of nurses in the acute care environment. A 2005 study used a combination of observations and interviews to study the clinical decision making of nurses on a variety of units (Potter et al., 2005). The study focused on the nurses working through the nursing process and how they cognitively managed interruptions. The results demonstrated nurses work in nonlinear and multifaceted. In the study, the nurses experienced up to seven cognitive shifts an hour; a cognitive shift is a change in focus such as from one patient to another patient or one task to another task. Examples of unplanned cognitive shifts include call lights, clinical alarms, or other interruptions. These findings are significant to this study,

because cognitive shifts can result in loss of attention to patient's needs and omission in care. Potter et al. (2005) findings support that some staff may be unwilling or unable to deal with the significant member of unplanned cognitive shifts particularly if they are numerous or if the nurse is fatigued. This may have contributed to the comments in regards to responsiveness revealed in the interview as a factor considered in the overall rating of the hospital stay. One of the study participants noted, "A room where a lady had respiratory problems and she was using a machine that beeped if she turned over on her back. And the beep was really, really loud." As Potter indicated, alarms are considered an interruption and result in unplanned cognitive shifts among the nurses. This may have resulted in the continued alarming of the machine for an extended amount of time, creating further dissatisfaction among the patients.

Communication

A study comprised of hospitals across the United States and Europe found nurse staffing and the quality of the hospital work environment (managerial support for nursing, good doctor-nurse relations, nurse participation in decision making, and organizational priorities on care quality) were significantly associated with patient satisfaction, quality and safety of care, and nurse workforce outcomes (Aiken et al., 2012).

A 2008 study of 664 registered nurses (RNs) on 34 acute care inpatient hospital units used a regression analysis to show the interaction between the independent and dependent variables when studying the nurses' work environment and nursing outcomes (Tervo-Heikkinen, Partanen, Aalto, & Vehvilainen-Julkunen, 2008). When the staffing was adequate, RN job satisfaction ($B=0.001$) and patient satisfaction ($B=0.018$)

significantly increased. When regression analysis showed an increase in respect and relationships, there was a statistically significant decrease in job-related stress ($p=0.013$, $b1=4.329$), an increase in RN job satisfaction ($p=0.002$, $b1=7.376$) and an increase in patient satisfaction ($p=0.039$, $b1=0.053$). Lastly with an increase in the standards of professional nursing subscale, patient satisfaction showed a statistically significant positive increase ($p=0.015$) (Tervo-Heikkinen et al., 2008).

Summary

In today's world of VBP, patients' perspective of their experience, however subjective, is imperative. The significance of a positive patient experience is considered by many to be a nursing quality care indicator. Although the nurse is able to describe how care is being provided, only patients can articulate how their care should be provided. Meeting the patients' expectations of their experience is essential from both a financial and a competitive environment.

It is important for organizations to strive for the delivery of quality care and to appreciate what the consumers, their patients, feel constitutes quality care.

The environment of healthcare is changing hospitals must provide each patient with a positive experience and educate their employees on the relevance and reality associated with this requirement.

Chapter 3

The purpose of this qualitative study was to obtain a broader understanding of the contextual factors influencing a patient's overall rating of their hospital stay on the Press Ganey HCAHPS survey completed post-discharge. This study explored the hospital experience from the patient's perspective and identified key drivers that influence the rating. In this chapter, the study methodology is discussed along with sample selection, data collection, and data analysis. Rigor and ethical considerations are also presented.

Research Design

A patient's perception of his/her lived experience during a hospitalization is the objective reality for the individual. A hermeneutic qualitative approach was selected to explore and understand the concept of a patient's *overall rating* for the hospital according to that lived experience. This concept from a patient's perspective has not been well developed in the literature as evidenced by the lack of published research.

Phenomenological studies can be classified into Husserl's descriptive phenomenology, Heidegger's (trans. 1962) interpretative/hermeneutic phenomenology, and Merleau-Ponty's existentialist phenomenology. Each approach developed different steps

to data collection and based its analysis on the above-identified types to achieve the principles of grounding, reflexivity, and humanization (Holloway & Wheeler, 2010). The different but overlapping philosophical movements that gave rise to the phenomenological method are typified by the philosophical views of the authors and their followers.

This study investigates the lived experience of participants and the meaning of the phenomenon of study to them (Polit & Beck, 2012). An interpretive phenomenology approach based upon Heidegger's work was selected to provide a method of gaining a deeper understanding of the phenomena of concern through the lived experience of the participants (Creswell, 2007).

Asking persons to reflect or tell stories about their experiences is empowering, as well as effective in revealing common meanings of those experiences in an interpretive phenomenology venue. The lived experience of hospitalized patients is the focus of this study, hence, the phenomenological approach. In order to fully understand the rating a patient might give to a hospital on the HCAHPS survey fully, one must understand the experiences of the patient, as well as how the patient thinks and feels about his or her experience. A lived life experience contrives apropos phenomenological research topics (Holloway & Wheeler, 2002). Phenomenological research focuses on interpreting "the meaning of events and interaction to ordinary people in particular situations" (Bogdan & Biklen, 1998, p. 23). Hermeneutic research is the branch of phenomenology engaged to investigate the factors influencing the overall rating of the hospital. A qualitative study utilizing an interpretive hermeneutic-phenomenological methodology may provide insight into the environmental, situational, and personal factors influencing a patient's

rating of the overall hospital experience on the HCAHPS survey. The philosophical and methodological framework for hermeneutics was selected to interpret decision-making descriptions expressed by patients. This hermeneutical-phenomenological approach places emphasis on the lived experience of patients. The use of the interpretive phenomenology also bridges subjective and objective knowledge by focusing on the individual perceptions of phenomena under investigation while uncovering common themes that emerge from the lived experience of the person (Tarzian, 2000). Asking people to reflect and tell the stories of their experiences is an effective method to uncover shared practices and common meanings of those experiences. Interpretive phenomenology analyzes the narrative experience and interprets an understanding from where that experience is derived (Benner, 1994). The method acknowledges the researcher's personal beliefs while seeking to explore the lived experience of individuals experiencing a certain phenomenon. The hermeneutic approach also builds on the researcher's prior experiences as a source of knowledge and allows for a better understanding in the meaning behind the participants narratives. This method offers *acumen* of how a given person in a specific context comprehends a given phenomenon. Heidegger posited interpretive phenomenology involved examining how a phenomenon appeared and analyzing to make sense of it (Holloway & Wheeler, 2010).

Heidegger (trans. 1962) declared nothing can be encountered without reference to the person's background understanding, and every encounter entails an interpretation based on the person's background, in its historicity. The framework of interpretation we use is the foreconception in which we grasp something in advance (Holloway & Wheeler, 2002).

Examination of the concept *patient's overall rating of the hospital* through the lived experience of the patients provides rich data for analysis and interpretation, which reveals not only how they respond, but the contextual factors that influence their responses (Smith, Flowers, & Larkin, 2009). The six activities comprising the methodological structure of interpretive phenomenological research study include:

1. Turning to a phenomenon which seriously interests us and commits us to the world;
2. Investigating experience as we live it rather than as we conceptualize it;
3. Reflecting on the essential themes which characterize the phenomenon;
4. Describing the phenomenon through the art of writing and rewriting;
5. Maintaining a strong and oriented pedagogical relation to the phenomenon;
6. Balancing the research context by consider parts and whole (Van Manen, 1990, p. 30-31).

These six steps form the procedural blueprint for this study.

Holloway and Wheeler (2002) noted these inherent assumptions to interpretive phenomenological methods include believing participants are knowledgeable about the topic under investigation and honest without intentionally concealing aspects of their experience. Thus to further understand the concept of “the patient’s overall rating of the hospital” during their patient experience and the factors that influence this concept, it was necessary to study the lived experience of the patients who experienced this concept.

Research Aims

1. Gain a broader understanding of the patient’s experience from the patient’s perspective.

2. Identify key drivers that influence a patient's rating of his/her overall hospital experience on the HCAHPS survey.

Sample

Research site. The setting for this research study was a tax-exempt hospital located in southern California. The hospital is a part of a two-campus one-license community hospital and larger academic medical center. The research site is a level 1 trauma center with 700 acute care licensed beds, over 3,000 employees, and 1,300 physicians. The hospital is part of a large five-hospital system. The system employs a small group of commonly shared staff; however, for the majority of time each facility and the units maintain their own staff. Some director-level leaders manage more than one unit within the hospital and some maintain system wide responsibilities. This site was chosen based on the researcher's affiliation with the health care system and the specific hospital.

Sample selection. An initial purposive sample of 20 participants was sought from the population of the patients receiving and completing HCAHPS surveys after a minimum of a one-night stay in the inpatient hospital setting. The final sample size was determined based on data saturation. For the purpose of this study, participants were required to meet the following inclusion criteria: completed the name and contact information on the HCAHPS survey and must have had an inpatient stay within the past three months. The three-month criterion was established to ensure the participants had adequate memory of their exposure to the phenomenon of concern in order to have experiences upon which to reflect.

Sample access. To obtain access to the participants, the researcher met with quality department representatives from the facility, as well as the patient satisfaction liaison for the system and explained the purpose of the study. A letter of support was obtained from the Quality Department of the hospital (see Appendix G). Prospective participants were contacted via telephone from the information provided by the patient on the HCAHPS survey, also indicating that they may or may not be contacted. The participants were called and asked several tiered questions. Due to the historical difficulties of forming focus groups at this facility, the researcher's initial question asked participants if they would be willing to participate in a focus group. If the participants were interested in attending a focus group, the researcher provided three dates and times to attend, including two weekday evenings and one weekend morning. Those interested in attending were offered to be scheduled into a focus group session. The participants were informed the estimated duration of each session was one hour maximum. However if the participants were not interested or willing to attend the focus groups, they were then asked if they would be willing to participate in a brief telephone survey. The researcher encouraged the participants to complete the telephone survey at that time. However, the participants were also offered to schedule a follow up phone call on a date and time of their choice in order to provide an optimal environment to conduct the interview. The researcher was only able to obtain two participants willing to attend the focus groups when asked on the initial call. As the researcher identified there would not be enough participants to conduct focus groups, the two participants who had agreed to participate in the focus groups were contacted. The researcher was only able to reach one of the two

participants. This participant did agree to complete a telephone interview in lieu of the focus group, and did so. The final sample size consisted of 20 phone interviews.

The potential sample of participants was derived from a generated comments report from Press Ganey from HCAHPS surveys. The information received on the report was generated based on surveys received on or after September 1, 2013 by Press Ganey. The report contained the patient's name; phone number; discharge date; date survey was received by Press Ganey; specialty area; unit; days in the hospital; sex; age; language of the survey; zip code; diagnosis related group (DRG) code; IT unit; IT specialty code; and IT admit code. If the patient provided a comment and/or phone number it was also listed. Most significantly, the report contains the patient comments, as well as containing an area that indicates, "May we contact you."

The researcher divided the sample by the ratings assigned to the comments; positive, negative, or mixed. Press Ganey automatically codes the comments as positive, negative, or mixed. The researcher then created a calling list based on the discharge date, most recent to furthest out. The earliest discharge date was September 1, 2013 and the most recent was October 3, 2013. The researcher excluded any participants who indicated Spanish as the language of survey, due to the researcher's limitation with the Spanish language. Patients who did not leave a phone number or those who indicated a "no" on the "may we contact you" question were also excluded. The interviews were conducted by the researcher and were recorded with a small digital recorder. The researcher also wrote key notes in the event the recorders failed, as well as to capture field notes (See Appendix E).

The following interview ritual occurred to promote consistency when questioning participants and recording their responses:

1. Inform the potential participant of the study being conducted and obtain agreement of participation. (See Appendix A)
2. Obtained consent, including the use of audio recording device, prior to initiating the interview via verbal confirmation of consent. (See Appendix B).
3. Reviewed an interview guide with general statements as to the purpose of the interview, recording declarations, and the assurance of confidentiality. (See Appendix C).
4. Informed patients that detailed notes would be recorded throughout the session in addition to the audio device.
5. Conducted the interview following the Interview Guide. (See Appendix C)
6. Restated the participants' account to ensure accuracy and recording periodically.
7. Obtained demographic information (e.g., birth year, marital status, gender, address, number of hospitalizations in the past year) at the end of the interview. (See Appendix D).
8. Concluded each session by thanking each participant for their participation.
9. A certified transcriber transcribed the recordings of each session verbatim.

Procedures. The initial intent was to form focus groups for the study, however, historically, this has sometimes proven difficult. In preparation for difficulty in creating focus groups, other options were offered for data collection. The initial telephone contact script first asked the participant if they would be interested in participating in a focus group located at the hospital. If the participant answered “yes” then further details,

including a variety of dates and times were provided. However, if the participant answered “no,” they were then asked if they would participate in a brief phone survey. In attempts to decrease distraction and allow for privacy of the participants, the researcher provided the option for the researcher to be called back at a scheduled time and date, in order to provide for a more focused interview.

A total of 51 attempted phone calls were made to invite people to participate in the study. The potential subjects were first asked if they would be interested in attending a focus group located at the community hospital, on any of three potential dates. Only three participants indicated they would be interested and able to attend a focus group session. Two of the participants could attend on the Saturday and the third could only attend on a Tuesday. Due to the lack of research participants, the focus groups were cancelled and the study was changed to telephone interviews. Three people who had agreed to participate in focus groups were re-contacted and asked to complete a telephone interview in lieu of the focus groups. The researcher was only able to reach one of the focus group candidates for a complete phone interview. The other two were left messages and the researcher received no returned calls.

Seven of those contacted did not participate in the survey. Two declined both the focus group and the telephone interview due to “health issues.” Another stated she “had more things on my mind, like disability,” and refused all options, including the scheduling of a phone interview. Another declined all options to be interviewed, however did not indicate any reason. Two expressed a desire to participate in a scheduled phone interview, however when they were called back, the persons could not be reached. The final person who was not interviewed was initially scheduled for a focus

group; however because of the lack of participants, the focus groups were cancelled. There was an attempt to reach this person to pose the possibility of a phone interview; however a message was left with no returned call.

The most frequent reason for not participating in a focus group (six subjects) was due to the distance from where the participants reportedly lived, as well as their difficulties with transportation. Of those who provided a reason for not wanting to participate in focus groups, two reported they would be out of town for the presented dates, and one reported he had a friend coming into town. While one person noted she would “rather do a phone interview,” Novick, 2008, reports decreased cost and travel as one of the advantages of phone interviews over other means of qualitative research.

The participants were first informed of the study and introduced to the researcher, consented for audio taping and received information regarding the informed consent (Appendix B). The researcher then followed the interview guide (Appendix C) to complete the telephone interview. The researcher also used a form for field notes in order to document the participant’s interest and ability to participate in focus groups, or their interest in a telephone interview (Appendix A).

Participant management. The participants were called from the contact information provided by the patient on the HCAHPS survey.

Data collection. The patients’ responses on the overall rating of their hospital stay was explored using individual interview techniques. The researcher’s ultimate goal in conducting interviews was to understand the participants’ experiences as it pertains to the phenomenon. When exploring the patient experience and the patients overall rating of a hospital on the HCAHPS survey, interviews provide a method of receiving insight

into the phenomenon of the patient experience under review. The final number of interviews was determined with data saturation. Data collection was completed once data saturation had been achieved.

Session management. The researcher started each session by informing the participants the session would be recorded digitally. The researcher next explained the purpose of the study, as well as the risks and benefits of the study. The participants were also informed they could withdraw from the study at any time, ask questions about the study, or refuse to answer any question posed by the researcher. The researcher then read the participants the Consent Form (Appendix B), and requested verbal understanding and agreement to the interview. Upon completion of the interview, the researcher then asked the participants demographic information (Appendix D).

The patients were advised there were no right or wrong answers and the goal of the discussion was to identify their opinions, beliefs, and knowledge-related factors influencing their overall rating of the hospital on the HCAHPS survey. The researcher instructed the participants it was not required or requested that they share their overall rating of the hospital as scored on the HCAHPS survey. The participants were advised of their rights to confidentiality on aspects of their experience they did not wish to share. They were discouraged from sharing their medical conditions, diagnosis, and names of providers.

The researcher utilized an interview guide during each call in order to promote consistency among the interview and elicit feedback (Appendix C). Each interview included nonthreatening questions to facilitate comfort in voicing viewpoints and engaging in discourse. The researcher asked questions in order to facilitate the

participant's engagement. She asked the initial questions in order to beseech the participants' accounts of their experiences during hospitalization that influenced their overall rating of the hospital, as well as their experience in completing the HCAHPS survey post discharge. Upon completion of the interview, participants were again reminded of the confidentiality provided by the researcher relative to the discussion. The demographic questionnaires were completed. The participants were thanked for their participation. After each phone call, field notes and tapes were labeled with the time and date of the interview. After each interview, the researcher reflected on the dialogue from the participant.

Data management. At the completion of each interview, the digital recordings were uploaded and sent to a service for transcribing. Information on the tapes was transcribed verbatim by a trained transcriptionist (e.g., laughter, pauses). The estimated time of transcribing was three to five days after each interview was completed. The researcher reviewed the written transcripts against the digital recordings to ensure accurate transcription of the interviews. Once accuracy and completeness of the transcripts were confirmed, the digital recordings were erased.

The researcher requested that a wide margin be maintained on the transcripts in order to facilitate the coding and categorizing of information on the transcripts. The researcher commentated each recording with factual, field, methodological, analytic, and personal notes to provide a complete narrative transcript of the interviews. The researcher omitted or coded any specific contextual details, in either the audio file transcripts or field notes, relevant to the identity of the participants. The demographic information responses were aggregated. All participant information, consent forms, and

annotated transcripts were kept in a locked cabinet in the researcher's home office.

These items will be maintained for five years.

The researcher proceeded with collection of demographic information from each participant (See Appendix E). The investigator-developed demographic questionnaire included gender, age, ethnicity, zip code, and number of hospitalizations within the past year. A question about the reason for hospitalization, medical or surgical, was asked as well as the point of entry into the hospital for the patient (e.g., Emergency Department, direct admit, planned hospital admission) (See Appendix D).

Data analysis. Data were analyzed in stages as employed by Ajjawi and Higgs (2007). Their goal was “to maintain closeness (or faithfulness) to the participants’ constructs, grounding interpretations in the data” using hermeneutic phenomenology (p. 621). Data analysis steps included: immersion, understanding, abstraction, synthesis and theme development, illumination and illustration of phenomena, integration, and critique. Data analysis could occur concurrently with data collection in interpretative phenomenology. Holloway and Wheeler (2002) warned against immediately coding transcripts in categories at the risk of fragmenting the ideas to be found in the data.

Rigor. Although the concept of rigor has its origin in science and is seen more in quantitative research, there is a place for rigor in qualitative research as well (Holloway & Wheeler, 2010). Qualitative rigor refers to thoroughness and competence. Rigor in this study was achieved through the establishment of trustworthiness. In qualitative research, trustworthiness means methodological soundness and adequacy.

Trustworthiness is made possible through demonstrating dependability (reliability),

credibility (internal validity), transferability (external validity), and conformability (objectivity).

The researcher demonstrated dependability by describing the context of the research in detail. Dependability was confirmed via the maintenance of an audit trail that allowed another researcher to follow the same process and repeat the study with similar circumstances and participants (Holloway & Wheeler, 2010). In this study, all data were carefully maintained and documented to ensure an accurate accounting of the processes used in the study. A process was developed for referencing all statements and subsequent themes to original narratives from which they were drawn.

Credibility or internal validity was established by identifying concepts and restating them with the participants to ensure proper interpretation. The researcher established credibility by identifying commonalities in prior transcript analysis with emerging comments of each additional session. The interview format used in this study involved asking general, open-ended questions about the participants' experiences during their hospital stay. This allowed participants to speak freely of their experiences and produced rich, detailed descriptions of those experiences.

Confirmability was established via reflexivity, which entails reflecting on one's own biases (Plummer-D'Amato, 2008). This was achieved through self-reflection and disclosure of the researcher's background and personal feelings about the subject of study. Additionally, the researcher displayed intellectual honesty and openness by ensuring an audit trail that assisted with the identification of constructs, themes, and their interpretation (Holloway & Wheeler, 2010).

Ethical considerations. This study was approved by the University of San Diego Institutional Review Board and the Quality Department of the target hospital prior to the commencement of participant recruitment. Once permission and approval was obtained from both institutions (Appendix F & G), the researcher contacted the hospital HCAHPS survey project data manager for sample extraction. The researcher developed a purposive sample of the patients authorizing the hospital to contact them, as indicated on the survey form. The sample comments were categorized as positive, negative, or mixed based on Press Ganey's interpretation of the patients comments. The contacts were also listed in descending order based on the date of their hospital stay, the most recent being October 3, 2013, and the earliest, September 1st, 2013.

Participants' names were deleted from the audio file transcripts and field notes. In addition, any specific contextual details potentially revealing the identity of the participants were changed. All demographic responses were aggregated. Audio files were destroyed once the transcripts were verified for accuracy by the researcher. All participants' information, consent forms, and annotated transcripts are kept in a locked cabinet in the researcher's home office. These items will be maintained for five years.

Ethical considerations in this study included obtaining informed consent and maintaining participant confidentiality (Holloway & Wheeler, 2002). At the beginning of each interview, the researcher outlined the purpose of the study and the possible risks and benefits to the participants. Participants were informed they might become tired during the interview or have reoccurrence of previous emotions or anxiety from their hospitalizations, and were told the researcher would provide resources if this did result.

There were no direct benefits to the participants; however, they might be helping healthcare personnel learn about the patient experience from the patient's perspective.

To ensure adequate disclosure, each participant was read the Consent Form (See Appendix B) outlining the purpose of the study and provided contact numbers for further information. To uphold the voluntary nature of the study, the researcher informed participants they could withdraw from the study at any time and/or refuse to answer any of the questions posed. To ensure comprehension, participants were given the opportunity to ask questions about the study at any time. There were no identified existing power relations between the researcher and the participants that might be perceived as coercion.

The Researcher's Reflection on the Phenomenon

Prior to conducting an interpretive phenomenological study, it is important that the researcher reflect on his or her experience with the phenomenon under study. These reflections should assist with identifying any bias the researcher might have toward the phenomenon at the time of analysis (Van Manen, 1990). The hermeneutic approach allows the researcher's prior experiences to be recognized as a source of knowledge to identify meanings that might be presented in the narratives; however, this should not result in bias. The following statements were this researcher's initial reflections on the subject:

- The researcher is an Emergency Department Director with experience in a variety of leadership roles over the past 10 years. Prior to leadership positions, the clinical roles included the Emergency and Trauma Departments.

- The researcher has led or participated in a variety of projects and committees related to patient satisfaction and the overall patient experience. She has spoken with multiple patients and families, both positive and negative, related to their hospital stay experiences.
- She has been hospitalized and had a family member hospitalized.
- As a leader in a large health care system, the researcher is engaged in a variety of projects targeted at increasing patient satisfaction as reflected within the VBP reimbursement program specific to the HCAHPS.

As healthcare continues to exhaust ideas, finances, and human capital toward this initiative, dissection of the patients' interpretation of their hospital experience, as well as the HCAHPS scoring itself is needed. Patients are not informed about the significant impact of HCAHPS survey responses, both financially and operationally, on healthcare facilities. Furthermore, CMS restricts the extent hospitals may educate or discuss the HCAHPS survey with patients during or after hospitalization. Recent legislation tied this subjective HCAHPS survey to the hospital reimbursement and payment. The consequences of the survey results may not be fully understood by the respondents.

Summary

The significance of a positive patient experience is evident in the literature reviewed; however, the intricate contextual variables that influence the patient experience has been a topic of limited investigation. The specific interpretation and understanding from the patients' perspective regarding the overall rating of the hospital has not been a research topic. The dissection of the patients' thought processes in scoring on the HCAHPS survey is of utmost relevance when attempting to meet expectations, as well as

appreciating the variables that might influence the scoring, particularly as it relates to the patients overall rating of the hospital stay. It is significant both financially and clinically to the patients, as well as the institution and caregivers.

The first provision of the American Nurses Association (2008) Code of Ethics stipulated, “The nurse, in all relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (p. 7). The delivery of quality care includes not only the objective criterion that has been established by the governing bodies, but also the subjective aspect of patient satisfaction. Understanding patient satisfaction must include listening to and delivering upon patients’ expectations. This research postulated that the best teachers of the optimal patient experience are the patients; however, to learn about their experiences, health care providers must be open to listening.

Chapter 4

Results

The purpose of this qualitative study was to explore the patient experience from the patient's perspective and identify key drivers that influence a patient's rating their overall hospital experience on the HCAHPS survey. A phenomenological approach with focus groups was proposed with patients discharged from an acute care facility to identify these key drivers. The patient experience can be defined as a reflection of what actually happened during the care process and therefore provides information about the performance of healthcare workers (Kieft, Brouwer, Francke, & Delnoij, 2014). The patient experience serves as an indicator for evaluation and improving the quality of care within the healthcare environment. The patient experience is both recognized and solicited as a means of assessing healthcare delivery and a method for gauging patient centeredness (Edwards, et al., 2014). The significance of improving the patient experience can be seen in many different areas, such as an increase in patient satisfaction, reduced length of stay, improved outcomes for patients, and even cost reductions.

A hermeneutic qualitative methodology, as described in the previous chapter, was used to identify noteworthy themes representative of these contextual factors.

Unfortunately only two persons volunteered to participate in the focus groups. Therefore, semi-structured telephone interviews to identify the key drivers that influenced the patients' overall rating of the hospital during their hospitalization were conducted. After unsuccessful attempts to form focus groups the researcher transitioned to telephone interviews for data collection.

Data were collected from telephone interviews, using a semi-structured interview guide (See Appendix C). The use of semi-structured interviews allowed the participants to respond openly to a question and the researcher to probe for further explanations. The use of a semi-structured interview technique encouraged participants to narrate their own recall of the experience. This also allowed the interviewee to self-determine the hierarchy of importance in the factual recall, allowing for a self-emphasis on details. This proved to be a successful technique in this study.

Field notes were used during the interview; both the transcript file from the recorded conversation and the field notes were kept. The field notes allowed the researcher to document emerging ideas during the individual phone interviews, as well as the researcher's first reflective notes interpreting the data. This style guided the researcher to future prompting and reflexive inquiry in the subsequent interviews.

Sample Description

The sample consisted of 20 participants; of note, one participant was not the actual patient. She is the daughter of the patient and had actually filled out the survey for her mother, who is now deceased. Only the demographic information of this patient was

removed from the data and the sample statistics. The participants' average age was 66.7 $\pm$ SD years, with 52.6% being female. Sixty-two percent of the participants were married, 14% divorced, 14% widowed and 10% single. Eight of the twenty patients were admitted via the Emergency Room. Six of the patients were transferred from another hospital, five were scheduled for a planned surgery, and one patient was a direct admission into the facility (see Table 1).

Table 1
Participant Profile

Participant #	Age	Gender	Marital Status	# of Hospitalizations	Zip Code	Entry Site into the hospital
10	51	M	M	1	92116	ED
11	81	M	S	2	92103	ED
12	70	F	W	4	91945	Tx Outside Hospital
13	75	F	M	2	92021	Tx Outside Hospital
14	80	F	M	2	91901	Tx Outside Hospital
15	79	F	M	1	92118	ED
16	83	F	D	1	92037	Tx Outside Hospital
17	63	F	W	2	92114	Planned Surgery
18	85	M	W	1	92119	Planned Surgery
19	53	M	M	1	92104	Planned Surgery
20	80	M	M	1	92020	Tx Outside Hospital
21*	70	F	W	5	85365	ED
22	47	F	M	1	92021	Tx Outside Hospital
23	69	M	D	1	92116	ED
24	69	F	*M	1	92029	Planned Surgery
25	30	F	M	1	92106	Direct Admission
26	83	M	M	1	92116	ED
27	43	F	S	1	92108	ED
28	60	M	M	5	92057	Planned Surgery
29	67	M	M	1	91218	ED
30	69	M	D	1	92116	ED

21 Participants

Average age was 76 years $\pm$ SD	Widow - 3	14%
Average number of hospitalizations 1.71 $\pm$ SD	Single - 2	10%
Married - 13	Female - 11	52%
62%	Male - 10	48%
Divorced - 3		14%

Table 1: Participant Profile

The average number of hospitalizations in the past two years was 1.71 $\pm$ SD; 65% had only been hospitalized once at this facility.

Benner, (1994), states the size of the sample is considered adequate when interpretations are visible and clear, new informants reveal no new findings, and meanings from all previous narratives become redundant. These conditions were met in this sample; thus it was considered this study had an adequate sample size.

Findings

A total of 20 phone interviews were completed. Fifteen of the subjects recalled receiving a “survey” in the mail after their hospitalization, four were unsure on their recall, and one clearly did not recall the survey. The participants were then asked their recall of the specific study question, “Using a number from 0 to 10 where 0 is the worst hospital and 10 is the best, what number would you rate the hospital during your stay?” Eleven of the participants remembered the specific question, “Using a number from 0 to 10 where 0 is the worst hospital and 10 is the best, what number would you rate the hospital during your stay?” four did not, and five were unsure. The average length of the recorded portion of the telephone interviews was 8.84 minutes $\pm$ SD. The shortest call

was four minutes while the longest was 21 minutes. On the conclusion of the interview the researcher asked the participants six demographic questions (Appendix D).

Data Analysis

The examination of the concept of the “patient’s overall rating of the hospital” through the lived experience of the patients provides rich data for analysis and interpretation, which reveals not only how they respond but the contextual factors that influence their responses (Smith et al., 2009).

Hermeneutic interpretive phenomenology analyzes practical acts of living through narratives to reveal meaning; this method increases sensitivity to humans’ ways of being-in-the-world rather than providing theory for generalization or predication of phenomena (Crist & Tanner, 2003).

The data were analyzed in stages described by Ajjawi and Higgs (2007). The steps included: *immersion, understanding, abstraction, synthesis and theme development, illumination and illustration of phenomena, and integration and critique*. The final product is themes and stories (See Table 2).

Table 2
Data Analysis Plan
Ajjawi & Higgs, 2007

Stage	Step	Action	Data Sets
Stage 1	Immersion	*Organizing the data-set into texts, iterative reading of the texts and preliminary interpretation of the texts to facilitate coding	
Stage 2	Understanding	*Identify first order (participant) constructs	Physicians Responsiveness of Staff Discharge Follow up after Discharge Food History of the Hospital Personalized Care Interactions with the Staff Personal Hygiene Education Outcomes Diagnosis Personal Accommodations Skill of the Staff Communication, Verbal and Non-verbal Caring Technology of the Equipment Patient Rooms Staff
Stage 3	Abstraction	*Identify second order (researcher) constructs *Grouping second order constructs in sub-themes	-Human Interaction and Caring -Physical Structure and Technology -Attentiveness -Patient and Process Outcomes -Discharge and Follow Up

Stage 4	Synthesis and Theme Development	*Grouping sub-themes into themes *Further elaboration of the themes *Comparing themes across sub-discipline groups	-Human Interaction -Caring Behaviors -Hospital Accommodations and Procedures -Transition to Home
Stage 5	Illumination and Illustration	*Links the literature to the themes identified prior and reconstructs interpretations into stories	-Human Interaction -Caring Behaviors -Hospital Accommodations and Procedures -Transition to Home
Stage 6	Integration and Critique	*Critique of themes by researcher and externally *Reporting the research findings	

Table 2: Data Plan Analysis

Ajjawi and Higgs further developed each stage of the analysis from phenomenological and hermeneutic principles. The *immersion stage* (1st stage), includes organizing the data set into texts, iterative reading of the texts and preliminary interpretation of texts to facilitate coding. The data were analyzed during this immersion stage to identify data sets and preliminary interpretation. This entailed several readings of the transcripts and mental identification of similarities and themes that were obvious to the researcher. However the researcher was cautious not to begin forming constructs at this time, but focused on reading and interpretation of the transcripts. Data analysis can occur concurrently with data collection in interpretative phenomenology. Although, Holloway and Wheeler (2010, p.237) warn against immediately coding transcripts in categories for it might, “fragment ideas contained in the data.”

The second stage, *understanding*, is identifying first order (participant) constructs and coding of data. This refers to the participants’ ideas expressed in their own words or

a phrase, capturing the precise detail of what the person is saying (Ajjawi & Higgs, 2007).

A construct is defined as an image, idea, or theory, especially a complex one formed from a number of simpler elements. The researcher was able to identify significant emerging constructs from the interviews, such as human interaction and “caring” being an overarching construct noted during this stage. Participants expressed ideas such as caring behaviors and personalized care. They described verbal and non-verbal communications, while describing both physicians and other staff members. The researcher further categorized “caring” as a relationships construct, based off of interactions between participants and the staff. Physicians also emerged as a clear construct in this stage of *understanding*. Other developing constructs included; discharge, patient rooms, food, personal accommodations and hygiene care, staff responsiveness, and technology of the equipment. Participants also referenced education that was provided as well as the skill of the staff. The hospital’s historical significance to the participants was also noted in several interviews. Diagnosis and outcomes also were identified in this second stage of analysis, as well as follow up after discharge. The constructs of this stage were based off of the interviewees’ responses and frequency of such; in this stage the researcher was not yet analyzing in depth, but trending common constructs reported in the interviews (See Figure 1).

Physicians	Non-Verbal Communication	Verbal Communication	Staff
Caring	Personalized Care	Food	Responsiveness of the Staff
Discharge	Patient Rooms	Personal Accommodations	Outcomes
Personal Hygiene	History of the Hospital	Diagnosis	Interactions with Staff
Follow up after Discharge	Education	Technology of the Equipment	Skill of the Staff

Figure 1: Stage 2 Constructs

The *abstraction* stage (3rd stage) includes identifying second order constructs and grouping second order constructs into sub-themes. The researcher was able to clearly identify and group specific constructs in the prior stage. Further analysis of the identified constructs in the second stage served as a sorting point to begin the *abstraction* of stage three. The sub-themes identified in this stage are formed from the constructs identified in stage two. Human interaction and caring was identified as major themes of this study. The construct included in this sub-theme were; communication, verbal and non-verbal, caring, physicians, staff, and interactions with staff. The interviewees also identified several constructs that were grouped into a sub-theme titled, physical structure, and technology. The constructs were history of the hospital, patient rooms, and technology of the equipment. The data revealed additional developing first order constructs which were

formed into the sub-themes titled attentiveness, patient and processes outcomes, and discharge and follow up. The attentiveness sub-theme included ideas or constructs such as responsiveness of the staff, personalized care, food, personal accommodations, and personal hygiene. The sub-theme titled patient and process outcomes included data referring to the skill of the staff, diagnosis or the lack there of and the outcomes of procedures. The final sub-theme was discharge and follow-up. This sub-theme included constructs such as, education, discharge, and follow up after discharge (See Figure 2). These five sub-themes were further analyzed and developed in stage four.

Figure 2: Stage 3 Sub-themes with Construct

Stage four in the data analysis is the *synthesis and theme development*. This includes grouping sub-themes into themes, further elaboration of themes and comparing

themes across sub-discipline groups. In this stage, the researcher analyzed, re-grouped, and titled the sub-themes (See Figure 3).

Figure 3: Stage 4 Synthesis and Theme Development

The initial sub-themes included; human interactions and caring, physical structure and technology, attentiveness, patient and process outcomes, and discharge and follow up.

Human interactions and caring theme was changed to human interactions and relationships. This theme was also felt to be inclusive of the next theme of attentiveness. The attentiveness theme included; responsiveness of the staff, personalized care, food, personal accommodations, and personal care. Personal care was inclusive of hygiene as well. On analysis, the researcher combined the sub-themes, human interactions and relationships, with attentiveness. The constructs of the human interactions and relationships included verbal and/or non-verbal communication, caring, physicians, staff, and interactions with staff.

Upon further analysis, the researcher divided and renamed the human interaction and relationship theme. The data analysis allowed further distinction into two separate themes, human interaction and caring behaviors. The human interaction theme was inclusive of verbal and non-verbal communication. The caring behaviors theme included; responsiveness of the staff, personal care, and personal accommodations. In addition the sub-theme of attentiveness was also categorized into the caring behaviors theme.

The participants also described physicians and staff who provided these interactions or with whom they had a sense of a relationship. The researcher kept physicians and staff separate as a construct, because in the majority of interviews, each was very independent of one another placing them in the human interaction theme. Participants described their history with the hospital with nostalgia. This included both

recall of people they have encountered at the hospital, as well as actual building itself.

They described a variety of memories. These included attending school there as a young adult in nursing school, as well as memories of delivering their children or other hospitalizations of friends or family members. As a result, the history of the hospital construct was moved to the theme of “human interaction.”

The sub-theme of caring was better defined as “caring behaviors” after analyzing the data, and appeared to be significant enough to be one of the major themes. Finally they expressed the personal care and accommodations that were or at times were not received. The researcher encompassed these themes in which human caring and compassion played an intricate part for the participants’ perceptions of their experience, and placed it in the theme of caring behaviors.

The next sub-theme was initially titled “physical structure and technology” and included the patient rooms and the technology of the equipment. Attached to the patient rooms were the foods that were re-grouped from another theme. The theme also described the food offered by the facility. In earlier stages, it included constructs such as history of the hospital; however this was re-categorized into the human interactions theme. Based on the data the researcher renamed this theme as hospital accommodations and procedures.

Another prior sub-theme, patient and process outcomes, combined the constructs, outcomes, skills of the staff, and diagnosis, into one theme. To avoid repetition of the theme and the sub-themes, the patient and process outcomes theme was also placed in the hospital accommodations and procedures theme.

The final theme was formed from based on the participants' recall of issues involving their discharge. This included sub-themes regarding education, discharge, and follow up after discharge. The researcher developed the new theme as transition to home.

In summary, the themes in stage four were consolidated from five themes to four and became; human interaction, caring behaviors, hospital accommodations and procedures, and transition to home (See Figure 3). In Chapter 5, the final stage, illumination and illustration of the phenomenon, will be described.

Human Interactions

One of the dominant themes identified by both the interviewees and the interviewer is that of human interaction. This category includes a spectrum of people, as well as interactions. The participants frequently used adjectives such as nice, helpful, wonderful, outstanding, and kind. One participant noted, “. . . the personal feeling that I had with the nurses.”

The major person identified and referenced was the physician. The interviewees spoke of the physician interactions on both positive and negative recalls. Several of the participants were able to recall the physicians by name. One participant reports she brought her mother from another state to the hospital specifically because of the particular physician practicing there and his knowledge:

“...was one of the infectious disease doctors who were there. That is why I brought her there. That, to me, is why I chose that hospital. Because we live in Yuma and they kind of knew what she had, but they weren't real familiar with it and he had done some research on it and knew about the disease. So that's why

he recommended us going there. I talked to him on the phone and he recommended us going there and that's how we ended up being over there."

The patients clearly spoke about the physicians on several levels, typically very pleased. There were also vivid descriptions of the relationship between the MDs and other staff members, and when positive, it produced a team alliance. However when it was not a positive interaction, the subjects described a hierarchy structure between MDs and the other staff. One of the subjects described the staff as belonging to the physician, "Dr. S's staff, on her two floors, are right on top of it." The positive relationship between the physician and the staff lead the subject to believe the staff worked for the physician when they are actually hospital employees. The positive and unified relationship displayed by the physician and the staff on this unit, elicited a comfort in the team and common knowledge between the physician and staff. The unit was viewed as an extension of the physician.

The hospital is a teaching facility, and several participants referenced the physicians in this manner as well. The abundance of MDs was synthesized as a positive attribute from the interviews, one participant recalls:

"And he was a fantastic surgeon. And he had his liver specialist with him and then I had a.. lung specialist there because I caught pneumonia right after surgery. I mean it was like the doctors just all were there all the time."

Although participants were able to recall several physician names, only one vaguely recalled a staff members' name, even though she described a personal connection with her and she was very pleased with her:

“This one little girl that lived in these apartments over-that I can see from the window where it was at, she just was-she made you feel like she was part of the family. There was one other that I think lived in Santee that made you feel the same way. And my daughter kind of connected with that one. I think her name was something like Laurie or something. I don’t remember.”

One participant reports extreme pleasure and gratitude for his nurse, and states “I wish I could remember his name, it was a male.” He described the care he received from the nurse:

“And the amount of information that he gave me was just amazing, the guy was amazing. And even the nutrition information that he gave me, when I was ordering lunches and my dinner and what I should be doing when I got home, was phenomenal.”

Even when the participants had a negative interaction with a staff member they did not recall names, but were able to give great detail. The researcher also noted that many times just one negative interaction remains on the forefront of the patients’ memories, regardless of the amount of positive interactions. A participant noted, “Everybody there was wonderful, except that one.” When asked to elaborate, she notes, “In fact, they were all really nice except him and that’s why it stuck in my mind so badly.” Another participant stated, “Everybody is friendly, with the exception of one person.” This interview supports the theory that one negative interaction will remain at the forefront above all others. It appears that regardless of a positive or negative interaction,

the participants' lack of recall of names was prevalent and considered the norm among the participants.

The human interaction and relationships theme includes both the verbal and nonverbal actions the participants witnessed or endured during their stay. The interviews revealed the value these interactions had on the participants. Staffs were described as being "good to me," and "treating me well" by participants. Another recounts, "but when I needed something, they were very responsive and they were just great people. Absolutely great people." Throughout the interviews staff was described as caring and nice by several people. One participant describes her perception of the check in questions she received:

"...asked me really pertinent questions about what was causing my stress level.

Was I in any danger in my home? And I really appreciated hearing questions like that. Not because I was in any danger in my home, but because of the stress level that being a caregiver carries. So there was a lot of understanding."

The non-verbal or lack of communication was just as impactful as the verbal communication to some of the interviewees. One interview details the interaction between the participant and a "sassy little nurse." The interviewee reported, "And then this sassy little nurse came in and pulled the bed out that had been all made and everything and put a crummy bed in there." The interviewer inquired further about the description of the "sassy little nurse." The participant reported, "No, I mean she just came in and she said, 'I'm taking this bed.'" When asked further about any conversations, the interviewee reported, "I didn't have any conversation with her." This

case exemplifies a lack of communication can bias someone to your actions, as in this case. Communication is one of the expressions humans use to show regard and care for others, however the lack thereof creates a negative impression as characterized above.

Several participants referenced the historical significance or a sense of nostalgia for the facility. This construct was placed in the human interaction theme. Interviewees referenced they or other family members were born in the facility. There were others who had previously been employed at the hospital or who were in the hospital as part of their clinical curriculum while they were attending school. A participant commented, “You know, I took my nurse’s training there 100 years ago.” One of the participants noted, “Whenever something happens I always go to [Hospital A], even though I had to change insurances to keep my [Hospital A], I always had [Hospital A] since 1950.” Based on these comments, the researcher can definitely determine the value of nostalgia and reputation related to the facility. The participants described a relationship to the building itself, the nostalgia for the hospital was evident in several of the participants.

Caring Behaviors

The attentiveness sub-theme was merged with the caring behaviors theme in stage four. Attentiveness emerged as a major sub-theme of this theme. This sub-theme was developed to encompass data referencing responsiveness of the staff, personalized care, and personal accommodations. The researcher evaluated and then merged this data with the caring behaviors theme. When a participant was asked, “what things that you took into consideration when you assigned the number to the overall rating of your hospital stay?” the participant replied, “The people that cared for me were the main

thing.” The sense of comfort the staff delivered to the participants reiterated throughout the interviews, one stated, “Everything was done smoothly and with kindness. You know, with consideration for my comfort and my peace of mind.”

Other areas encompassed in the sub-theme of caring behaviors were personalized care and accommodations, specifically the staff’s willingness to deliver personalized care to the individual. One participant reported, “I really think that it was the personal feeling that I had with the nurses” as one of major influences of her overall rating of her hospital experience. The examples are not only physical acts but caring behaviors that required process changes and accommodations to meet the specific needs of the patient. The most notable exemplars came from a participant who was placed on an overflow ward due to the lack of available rooms. This area is an open ward, with only one restroom. The area is meant to be for temporary stays until other rooms are available, at which time the patient is then transferred. When interviewing the participants he recalled:

“But I was blessed. I-because I suffer from depression and anxiety, and have an issue with being closed in, they left me in that area that is temporary holding area from ER to the hospital, so I was never in a room. I was in a room, actually, but it didn’t have a bathroom.”

This is a nursing unit that has a process initiative in place to increase patient throughput out of the ED, but it is not desirable to many patients. However because of this patient’s medical issue, he felt very comfortable there and staff accommodated him staying in the unit, which resulted in him being very satisfied with his hospitalization. He

noted, “That’s what I needed and the hospital was responsive to my needs and allowed me to stay there.”

The participants voiced satisfaction with having the ability to offer input and make decisions about their care and treatment. One participant spoke to being given the choice by the physician as to continuing with testing. Another participant described a discussion she had with the physicians in regards to her need of hospitalization verses homecare. She recounts:

“They did a really good job and one of the things that I thought was really important about the whole process I went through, and I was able to discuss it with one of my doctors when I had a follow up-you know the first day that I was there, was what-you know what’s the plan?”

One participant reported his unhappiness with the lack of fulfillment of his request for a priest. He reported there was some time lapse from his request to their arrival, “My wife verified that I asked for one and none came.” In addition the patient stated he requested a priest, however a chaplain arrived “at the end.” This participant felt his request was not met and the priest he requested was replaced by a chaplain, which to the participant held a significant difference. In contrast another participant reflected on her experience with the staff trying to meet the patients individualized needs. She recalled:

“That actually asked my mom if she could pray with her. And she sat there-and my mom is Buddhist. But she asked her to pray with her and my mom was like, ‘Yes,’ you know? Sat down by her and prayed for her. But when I came in she

was like, 'I just can't believe. This nurse came in and she prayed for me and she was so nice to me.' You know just those little extra touches that made it worthwhile for her to be there."

The importance of the patients' spiritual support is evident in the interviews among these participants, although different; there is evidence of the need and an expectation and satisfaction when the need is met.

The other type of support the participants mentioned included family and friends. One participant noted the significance of having her friends present:

"I don't know if it's helpful for every patient, and it is that I had really good support system of friends that were-because my family doesn't live here in town, but I did have a very good support system that was here in town to help me and to be there when I wasn't really myself, and they did a really great job of making some accommodations to allow me to have them there to support me while I was kind of going through some of the more difficult parts of it. That was really good."

The interviews revealed patients hold in high regard when staff engage in or assist in providing personal care, such as bathing and brushing their teeth. One interviewee recalled:

"Well I needed-I mean I was dying to take a bath, but I couldn't take a bath because half of my stomach was cut so I just couldn't. So I had to do the other kind of bath, and then she was real good about washing my hair and all that. So I

felt good after that, and she put lotion on my legs and-oh I mean I felt brand-new then.”

The same interviewee also continued to recollect about the back massage she received after the bath was “just out of this world.” Just as this participant was pleased with her personal care needs being met, another interview revealed the displeasure when a patient was not offered a bath. “The only negative thing was that I was not offered a bath until the last day. They finally brought me a pan with some water and a washcloth.” Throughout the interviews there was mention of personal care needs such as bathing and oral care by the participants as a point of satisfaction when met.

Participants held in high regards tasks that appear to be simple in nature. These duties might be as simple as placing a warm blanket on the patient or introducing oneself every day. A participant described one of the most admired acts from staff she appreciated, “even if they didn’t have something, like they had taken blood or something like that, they would just stop in and say hello.” This patient clearly enjoyed the simple “hellos” from the staff. Another interviewee recalled, “when people walked by, I could say hello, how are you? They’d say hello. Once in a while a janitor or something would come in and visit for a few minutes, so that’s what I needed.”

Another sub-theme of the caring behaviors theme is that of responsiveness of the staff as perceived and described by the participants. The word “responsiveness” was mentioned by several of the participants throughout the interviews. One participant stated, “I couldn’t have asked for better people, and more attention.”

An additional evolving construct in this theme was the sense of comfort patients need and feel from the staff. One participant notes feeling like, “I just felt like I was just shoved away in the corner and that there was nobody around to – I mean, she gave me my medicine, but I think the other thing is really more important.” As the discussion progressed the interviewee reported she had asked the nurse to come back, and she never did. This, as mentioned in prior statements, left the patient feeling neglected. Some participants noted exception in the most common of acts, while others appeared to have felt a void when these simple acts were not done.

Hospital Accommodations and Procedures

The hospital has a limited number of private rooms, so the majority of our participants spent some or most of their stay in as semi-private room, most the time with a roommate. Five of the interviewees noted specific complaints in regards to roommates; some of the interviewees had more than one unfavorable experience during their stay. One of the participants recalls, “They had me in with somebody that was contagious.” A study participant accounted when asked to elaborate her displeasure with being moved in the middle of the night:

“Boy that was a negative. And unfortunately, the lady that was in the room-it because they and another male come in and they needed to put two males in the same room and two females. So I went into a room where a lady had respiratory problems and she was using a machine that beeped when she turned over on her back. And the beep was really, really loud. I know this probably has nothing to do with it, but afterwards, about six days later I think it was, I lost the hearing in my left ear.”

In several interviews the participants acknowledged their roommates were sick and in distress. However they still strongly felt it as a negative aspect of their overall rating of their experience that they were in the same room as such a person. As one person recalls, "I went into the room that they put me in, there was another patient who, obviously, in my opinion, required a lot more care than I did." Although understanding of the level of acuity and distress this patient was experiencing, the interviewee still felt very negatively she endured the distraction. The same participant stated, "They have things they got to do that it just seems like they didn't really seem to be aware there was somebody else in the room." Although in reflection of prior interviews, when the patient appeared to be well informed of the reason for her move, to accommodate the need for male beds, the information did not seem to alter her level of frustration.

A different participant was moved twice during her stay and each time had significant issues with her roommates. Twice she was placed in a room with patients who were receiving dialysis. When these patients are being dialyzed, it rendered the bathrooms unusable in this room, per the participant, "which meant that, I couldn't be in my own room when they were having dialysis." The same participant also distinguished the issues around her family visiting related to the size of the room and the sickness of the roommate. There were also cultural issues discussed such as non-English speaking roommates, number of the family members that would visit, and the smells of the food being brought in with no consideration for the roommate.

There were three participants who discussed specific structural issues with the rooms. One person specifically recalled the showerhead in her bathroom:

“The showerhead, it’s removable only. And you have no option of leaving that. You know what I mean? And when you are hurting to wash yourself and everything and having to be holding that thing the whole time was not convenient for me.”

Others commented on the small size of the rooms, and the lack of space for belongings and visitors. One participant noted, “I was very cramped in my room, my wife had this little small chair in the little corner.” There were also examples regarding the moving of participants to different rooms at late hours. One participant noted, “There was one disturbing thing that happened to me, is I had to be moved in the middle of the night.” This appears to stem from the lack of private rooms at the facility.

Three of the subjects recognized issues with the apparent technology of the facility. One of the participants saw the technology as a negative feature, “. . . is that there is no admitting clerk any longer. They admit you after you get into the room and they have to use this computer and do all this work. Medicine isn’t what it used to be.” She again spoke to this when recalling her discharge, “It took an hour for her to enter everything into the computer.” She acknowledges the need for the computer systems, yet had obvious discourse in her perceived efficiency that the system offered.

Another participant mentioned the visually aged appearance of the radiology equipment:

“But one thing I didn’t like-it doesn’t really matter that much, but when I would have to go down for x-rays there was one part of the x-ray department that was really old, and the machines were awful. And you know that’s not to say that –

I'm sure the machines work fine because they are digital. Like, it was like, you know you'd-there was a little square with a plus sign on it on a piece of plywood that you had to lean up against. And you know it looked like-everything was all dark and dingy gray. So it looks like it was like out of the 50s, so. . .”

The person noted, when asked, this would not have carried weight when considering his overall experience, however he did have significant recall and details.

One of the major constructs identified by participants was the food provided to them during their hospitalization. Initially the construct of food was placed in the caring behaviors sub-theme, however after further analysis, it was moved to the theme of hospital accommodations and procedures. Participants described issues ranging from the actual process of receiving food, to the challenges of having food in semi-private hospital rooms.

Six of the participants offered a recollection of food when asked about the factors considered in their overall rating of the hospital. A participant referenced the nutrition information he was able to obtain from his nurse when ordering his lunch and dinners; he felt this prepared him better for when he would be faced with similar choices at home. There were others who mentioned their inability to have food, due to physician orders based on their diagnosis. However this appeared to be more of a result of their illness and did not appear to be in negative light. There was a negative comment regarding the aroma of her roommate's food and the fact she was dealing with nausea. This made the room an undesirable location for her to be in and is more reflective of the semi-private room situation.

The hospital has a process in place that allows the patients to order their meals most of the time, dependent of the time of day they are admitted. One participant noted, “They’re very attentive about you order what food you want, but still, it doesn’t seem like the options are all that suitable.” One participant noted, “That was the only negative, the food.” When questioned further, this participant indicated he was not able to pick my menu” and the food, “filled the tummy, but it just wasn’t satisfying.” One patient, who described the food as “okay,” shared the significance he felt hospital food carried:

“I almost would-tried-thought about getting an insurance that would put me at [Hospital B]. Because the cafeteria at [Hospital B] is awesome and I assume they’re fixing the food that goes up to the room, I don’t know, but their food-and that means a lot to a patient, having good food. I mean, that helps them get well, so the fact that food was decent, very decent, I was very pleased. I never had something that I was displeased with. That really thrilled me.”

This participant held far more significance to food than any of the others; however food was mentioned by 33% of the participants in this study.

The construct, cleanliness, was included in the hospital accommodations and procedures theme. There were only two participants who had feedback related to room cleanliness and housekeeping specifically. One participant notes:

“They got a housekeeper who rarely came in and when she did-she just grabbed the dirty clothes and that was it. I didn’t see her really clean the bathrooms. I didn’t see her sweep the floors, you know I didn’t see her do her job is what it was.”

One participant noted, “in terms of cleaning up the room and things. Yes, I think they’re a little bit, sometimes, casual about it.” In the same conversation this participant was alluding to the professionalism of the employees based on their employee class. He states, “Well, the higher up the,-you got like the doctors on duty, and so on. But really, fine people, but you get down in the lower in the employee class, not so good, you know?” Only 10% of respondents noted cleanliness as a factor they would consider when rating their overall hospital stay.

Process outcomes was previously considered to be an independent sub-theme however upon further analysis, it was placed under the theme of hospital accommodation and procedures. There was only one specific mention nursing skills, such as intravenous placement. The participant acknowledged the difficulty nurses have with obtaining an intravenous site, and she requested, “The lady who gets it.” There was also no mention of surgical sites, incisions, or dressing from the participants.

Transition to Home

There are several aspects that are sub-themed under the construct of transition to home. This included not only the actual process of the patient being discharged and events on the day of discharge, but the planning and preparing for discharge that participants commented on throughout the interviews. An additional sub-theme is follow up, several participants shared information regarding their expectations or hopes that might or might not have occurred after their discharge, or with follow up or lack thereof. This theme also contained data regarding education and teaching of the patients and/or family members.

.....In speaking to the actual discharge process, one participant commented on the time

it took to input the information into the computer and actually complete her discharge, this dissatisfied her. Another participant described an uncertain discharge process:

“It seemed to me, well not seemed to me, in fact it was-once she had given me the discharge papers and gone over the instructions, which she did, that was it. I was on my way. And in fact I had a hard time to find one of them to ask about a wheelchair.”

One participant recalled her distress of not receiving her “booklet” upon leaving. She said:

“I think the most important thing is that I wasn’t sent home with my booklet. You know, with what to do? Because they were a little bit busy trying to get me out of there, in a timely manner, that was overlooked and it had to be sent to me at home.”

In contrast, another participant relayed his dissatisfaction with what he felt was too much information, as well as an inefficient delivery method. He stated, “The hospital sends you an email for every test you have.” He reported he received 142 emails of test results after discharge; he described this as “ridiculous.” However interestingly, the same participant noted, “after the seriousness of my illness, not to get some kind of follow up phone call and say how you feeling? Is there anything you might have a question about?”

Although he did not appreciate the thoroughness of the emails, he appeared to miss what he valued in a simple phone call.

A statement used throughout acute healthcare is the discharge begins at admission, meaning you begin education from day one to fully prepare patients on their discharge date. One participant felt he was not fully prepared with education regarding an internal device he required on discharge. He stated, “I never had one of those things on me before, and you know really not much information at all.” On referencing the survey question he said, “I would knock it down for, because I don’t think they did a good enough job with that.”

Another person had a very positive experience with the information and education he received throughout his hospitalization, in preparation for discharge. He noted, “It was like his main thing was to take time to make sure that I understood what was going on.” This experience included nutrition information to assist him when he was at home in making food choices.

Several participants mentioned the need for further follow up after discharge. This however included a spectrum of topics. One participant had commented on the desire to attend support groups for his diagnosis that were not offered at the time of his diagnosis, but are now offered. Several of the participants indicated their disappointment with the lack of phone calls after discharge, whether it was due to a request related to a problem that was reported, or simply to ask them, “How they were doing?” There was definitely a significant theme expressing the desire for follow up among several of the participants.

A patient phone call upon discharge is supported by ED Management in a 2011 article stating, “Experts maintain that not only does this type of follow-up enable you to intervene quickly if there is a clinical problem, but patients also, naturally, appreciate having someone check up on how they are doing.”

Those who did receive follow up after discharge were very pleased:

“The aftercare people did a really good job too. They came to my house, they-you know, I had a nurse that showed up two or three times a week for the first couple of weeks taking my blood pressure and checking my blood sugar. And I was very pleased with the care that I received.”

Impression of Researcher

On reflection, the researcher’s first impression identified a trend among participants that included their ability to recall a single negative interaction with a particular person. Typically, patients reflected with vividly detailed recall about the person who was part of an unfavorable interaction. Many of the participants, who described one negative interaction among many other events during their stay, referenced other interactions as being “very nice” or “ok” with vagueness and little detail. However they were able to clearly identify and elaborate on the negative encounter with great detail. The participants reported more meaningful details on negative encounters, than those encounters they were extremely happy with. Otherwise, the interviewees lacked specific particulars of events or people.

Upon further reflection, the researcher identified that participants spoke of human interactions more frequently than any other aspect of their stay. There were a few participants who indicated issues with the equipment, technology, or processes, but the

majority of feedback, both positive and negative, involved human interactions. There were several participants who reflected on diagnosis and actual outcomes as a factor used in determining the overall rating of their hospital stay. The interview length varied based upon the participants being either very positive or very unhappy with their stays. The overriding theme throughout was the importance and significance placed on human interaction, not necessarily the tasks accompanied with the interaction, but the patients' sense of concern and care for them, otherwise known as empathy.

Conclusion

Using Ajjawi and Higgs approach to data analysis based on phenomenological and hermeneutic principles, the researcher was able to capture four major themes influencing the overall rating of the patient experience. The themes are; human interaction, caring behaviors, hospital accommodations and procedures, and transition to home. The themes were formed based on the constructs identified from the patient perspectives of their hospitalization. The analysis and continued development of the sub-themes and themes emerged through the stages of Ajjawi and Higgs (2007). The finalized four themes were found to have the most influences on the patient experience, while having significant impact on one another (See Figure 1).

Chapter 5

Discussion

Findings from this study are discussed with relationship to current literature.

Patient satisfaction and the patient experience are often used conversely. Patient satisfaction has been defined as the patient's subjective evaluation of their cognitive and emotional reactions as a result of interactions between their expectations regarding ideal nursing care and their perceptions of the actual nursing care (Johansson et al 2002).

Satisfaction includes cognitive evaluation and emotional reaction to the components of care delivery and services. Satisfaction is an individually subjective perception and is tied to one's expectations regarding their care and service. When expectations are not met, the result is a sense of low satisfaction. Even though data collection on patient satisfaction or experience is currently mandated in the United States, United Kingdom, Canada, New Zealand, Australia, and most European countries, there is not a consistent definition pertaining to the patient experience. Researchers suggest the "experience" is a unique involvement in or exposure to a certain event and as such a representative sample of a patient is unobtainable (Edwards, Duff, & Walker, 2014). The patient experience

can be defined as a reflection of what actually happened during the care process and refers to the process of care provisions (Kieft et al., 2014). Although lacking in definition, the Picker Institute identified elements of the patient experience as a means of measuring the patient experience. The two dominant themes identified by the Picker Institute were communication and care transitions. They established elements of the patient experience defined as “always events,” meaning that the elements were so important to the patient and families that it should always happen. The Picker Institute, 2013, identified the “always events” and the principles of Patient Centered Care (PCC) as the following: 1) respect for patients’ values, preferences, and expressed needs; 2) coordination and integration of care 3) information, communication, and education; 4) physical comfort; 5) support, alleviation of fear, and anxiety; 6) involvement of family and friends; 7) continuity and transition; and 8) access to care. This study supports several of these key elements identified by the Picker Institute as influencing the patient experience.

The purpose of this qualitative study was to explore the patient experience from the patient’s perspective and identify key drivers that influence a patient’s rating of the overall hospital experience on the HCAHPS survey. The telephone interviews transcripts were analyzed in stages according to the methods of Ajjawi and Higgs (2007). A visual depiction of the patient experience as described in this research is found in Figure 4. The four themes of human interaction, transition to home, caring behaviors, and hospital accommodations and procedure, impact the patient experience. The four themes have a reciprocal relationship with each other. See Figure 4.

Figure 4: Stage 5: Illustration of Patient Experience

The theme of *human interactions* contained several sub-themes; physicians, staff members, interactions with the staff, verbal and non-verbal communication, and history of the hospital. The expressed nostalgia for the hospital, as well as the reputation of the facility, was included in the sub-theme, history of the hospital. A European study found

that hospital reputation might be a positive parameter of patients' perception of care which could direct their choice (planned admission) to a specific hospital (Patiraki, et al., 2012).

Physicians were overwhelmingly mentioned throughout the interviews. One of the participants had brought her mother to the hospital after researching the physician online regarding his skills and practice treating specific diseases. So impressed with the physician, the participant and her family traveled from another state to this facility. A 2011 study of 467 patients in Minnesota found that the reputation of the physician, as well as that of the healthcare organization, held the greatest importance among patients when selecting a provider (Abraham et al., 2011).

Data indicated even when dissatisfied with other factors during the hospital stay, a participant is more greatly influenced by human interactions than other factors. A 2011 study by Holzer and Minder included interviews with a patient, his wife, and healthcare providers. People and communication as a determinant of a positive or negative experience were identified. Both groups interviewed agreed people are the key modifiers of the hospital experience, thus supporting the defining of the patient experience as "interpersonal aspects of care" (Holzer & Minder, 2011). The clear identification of people as the key modifier of the patient experience from all parties supports healthcare as a humanitarian industry. A study completed at Cleveland Clinic clearly identified patients wanted better communication, including their plan of care (Merlino & Raman, 2013). The study identified patients did not want to be in the hospital, they were afraid, terrified, confused, and always anxious. The patients and families wanted to know the people taking care of them understood what it was like to be a patient. Sharing a personal

connection has an impact on the alleviating a patient's and family's anxiety and promoting emotional security (Holzer & Minder, 2011). This act of sharing experiences and personal interactions between the patients, families, and providers, was highlighted as an essential element in creating a positive experience (Holzer & Minder, 2011). This element was supported with this research study; the participants shared personal facts about their care providers that were shared with them, supporting personal interaction as a positive aspect of the influencing the patient experience.

Initially, also encased in the human interaction theme were the sub-themes of attentiveness, responsiveness, and personalized care. However on further analysis, these sub-themes were placed under the theme of *caring behaviors*.

Caring is defined as acts, conduct, and mannerisms enacted by professional nurses that convey concern, safety, and attention to patients (Greenhalgh, Vanhanen, & Kyngas, 1998). In this study, the caring behaviors theme also included personal accommodations that were made specifically based on patients and/or preferences. In addition, personalized care and responsiveness of the staff were also categorized in the caring behaviors theme. A study at Cleveland Clinic found the importance of doctors' and nurses' demeanors on the patient experience. Patients were more satisfied when their caregivers were happy. The patients felt if their caregivers were unhappy, it meant either the patient was doing something to make them feel that way or something was going on that they did not want the patient to know (Merlino & Raman, 2013).

Caring is central to the practice of nursing and is the foundation of nursing practice. However it is a complex concept that varies based on a variety of things, such as culture, context, personality, or personal perceptions. A 2011 study of perceptions of

nursing caring behaviors used the Caring Behaviors Inventory instrument, the third-generation version which is reduced to 24 questions, (CBI-24) (Papastavrou, et al., 2011). The study compared six European countries; Cyprus, Italy, Hungary, Czech Republic, Greece, and Finland. The study found a statistically significant difference in the patient responses in the CBI-24 scale across the six countries ($F=26.925$, $P<0.001$). In addition, the results from the ANCOVA showed a statistically different response in the nurses' responses on the CBI-24 scale between the six countries ($F=24.199$, $P<0.001$). The study supports the variation of the perceptions of caring behaviors not only from patients and nurses, but across countries and cultures.

Caring behaviors may improve quality of care, as well as help to promote a sense of safety for patients and decrease their anxiety levels. A 2010 study found caring behaviors have a statistically significant ($p<.05$) impact on patient loyalty in emergency departments (Liu et al., 2010). The caring behaviors that had the strongest correlations with patient loyalty were; making sure the patient is aware of care-related details, working with a caring touch, and making treatment procedures clearly understood by the patient (Liu et al., 2010). These caring behaviors were reinforced by the data found in this study. Respondents of this study revealed similar significance to caring behaviors as previous studies. When caring behaviors occurred then patients had a positive experience, such as tone of voice, body language and facial expressions, communication, showing care and concern, and introducing themselves. However if these behaviors were conducted in a negative manner, the patients relayed a negative experience, with significant impact on their overall experience. Caring is fundamental to man's existence and is expressed in our interaction with fellow human beings (Martinsen, 2003).

The *hospital accommodations and procedures* theme was developed from food comments, skill of the staff, diagnosis, and outcomes. The researcher also included comments on the physical structure of the hospital, such as the rooms and available technology, or lack thereof, in the hospital equipment. There are many challenges with the physical structures of the facility, not only the technology items. One of the frequent negative aspects heard from the participants, was the lack of private rooms. The use of semi-private rooms is essential in healthcare due to patient volume and limitations on expanding hospitals. These are challenges not easily overcome. However it is evident from the data that through patient communication and education, the patients interviewed understood the reasons behind the use of semi-private rooms. Although the participants interviewed clearly understood the need for patients to share rooms, they did not have a tolerance for the lack of private rooms while hospitalized.

The physical environment is identified as a significant factor in determining a patient's overall satisfaction with healthcare services, only second to nursing quality and clinical quality (Harris, McBride, Ross, & Curtis, 2002). The national and international trend in healthcare is to build private patient rooms. Single patient rooms is set to become the standard in the US hospitals (Landro, 2006). In the United Kingdom and NHS Estates all the new hospitals are advised that 50%-100% of their rooms should be private (Dowdeswell, Erskine, & Heasman, 2004). In the Netherlands, hospitals are being built with only single rooms. The healthcare and architectural movement is to private rooms throughout all hospitals. Many studies show patients in a private room have more positive patient experiences than those in semi-private rooms or wards. Patients who were in a four-bed ward and then moved to a single room had moderate to

large positive effects on satisfaction with care (Janssen, Klein, Harris, Soolsma, & Seymour, 2000). Rooms that were characterized as more “appealing” resulted in a more positive patient evaluation of the physicians and nurses, as well as more favorable judgment on service aspects (Swan, Richardson, & Hutton, 2003). Hospitals with more private rooms have higher patient satisfaction scores (Kaldenberg, 1999). Although most research suggests private rooms increase patient satisfaction, there are some negative aspects to private rooms. Patients may feel lonely, less social interaction among patients, as well as a decrease in patient safety (van de Glind, de Roode, & Goossensen, 2007). The results of this study support the need for private rooms as a patient satisfaction driver. However one participant noted the concerns of the negative aspects of being in a private room and preferred to remain in an open ward. This proved to be a positive influencing factor on his overall experience.

There was mention of simple issues with the structure, such as the need for a shower head for one participant. The interviews revealed issues such as this one, which would have made a difference in the participants overall patient experience.

The researcher was genuinely surprised at the lack of emphasis on skill, knowledge, and outcomes among the participants. A 2011 study found when a patient was asked what mattered most about his hospital experience, he stated “operation, people, and family” (Holzer & Minder, 2011). His wife responded, “That the operation happened.” Nurses identified clinically competent nurses as a major element influencing the patient experiences of the quality of care (Kieft et al., 2014). Providers were asked to define the hospital experience. Some of the items mentioned included; the doctors and their skills, the care they received, and whether he feels he is getting better or not

improving (Holzer & Minder, 2011). Although in these studies, patients, families, as well as the caregivers place value on outcomes. However in this study, it was not identified as a major influencing factor on the overall rating of the patient experience.

A study by Kieft et al. (2014) study asked nurses, “What elements of their work and work environment influence the patient experiences of the quality of nursing care?” The study found several facilitating elements considered fundamental to improving patient experiences; clinically competent nurses, collaborative working relationships, autonomous nursing practice, adequate staffing, control over nursing practice, managerial support, and patient-centered care. The nurses identified cost-effectiveness policy, transparency, and accountability goals as inhibiting factors that prevent them from improving patient experiences. Specifically in this study, the patients described the importance of a collaborative working relationship as an influencing factor in the patients overall rating of their patient experience.

There was limited data regarding invasive procedures the participants experienced. Some participants did mention the outcome of their surgical procedure and its success. Another participant voiced the length of time it took to give her a final diagnosis, as well as misdiagnosis, influenced the overall rating of her stay. The researcher was able to identify specific actions or events participants identified as impactful to their consideration of the overall rating of their hospital stay.

The fourth and final theme is *transition to home*. This theme included the preparation for the patient’s discharge, the discharge process, as well as care after the patient was discharged. This theme encompassed aspects of the patient education and preparation for their discharge home, as well as aspects of the actual discharge

procedures, such as the process of obtaining and completing the discharge paperwork, and even the physical means as to which the patient left the room. There were specific sub-themes regarding the follow up after discharge, as well as the education and preparation the patient did or did not receive.

The increased emphasis on decreasing the lengths of stay in health care has significant impact on the patient's transition to discharge. There is less time to include the patient and family in discharge planning and teaching, resulting in the patient having a decreased preparedness for discharge. A 1992 study using a medical team to coordinate discharge and augment discharge planning resulted in statistically significant ($p < .05$, 95% CI) improvements in patient satisfaction (Moher, Weinberg, Hanlon, & Runnalls, 1992). Discharge readiness is not only essential for a positive patient experience, but a low perceived readiness for discharge has been found to be a strong predictor of difficulty with post discharge coping and readmissions (Weiss & Lokken, 2009). A successful discharge is accompanied by specific elements of discharge planning: 1) communication, 2) coordination, 3) education, 4) patient participation, and 5) collaboration among healthcare personnel (Carroll & Dowling, 2007). The results of this study support these findings. The participants said the failure of such elements as communication and collaboration among healthcare personnel resulted in a negative patient experience. However when the elements were met, the result was a positive patient experience.

The implementation of structured discharge processes have proven to be successful in not only decreasing the discharge time frame, but increasing the patient discharge readiness, and subsequently the patient satisfaction. A 2014 study based in a rehabilitation unit, conducted a pre and post intervention measurement after the

implementation of the DePART process for discharges (Knier, Stichler, Ferber, & Catterall, 2014). The DePART discharge process was developed by an inter-professional team using a Lean Six Sigma approach. The process included several factors that were instrumental in providing a positive discharge experience. The steps included: 1. the identification of a discharge date within one week of admission and the identification of a primary family caregiver, 2. Home evaluations to include a therapeutic opportunity for patients to practice troubleshooting strategies with the therapist, 3. Community outings structured with a patient-centered goal focus, 4. Receiving physician orders for medications and durable medical equipment 48 to 72 hours prior to discharge, 5. Prescheduling of necessary appointments for one week after discharge, 6. providing a patient discharge preparation checklist to engage and ensure patients and families know what to expect after discharge, and 7. Follow up phone call at 24 to 48 hours and 14 days after discharge, to provide support and resources to the patient. The study compared Press Ganey patient satisfaction scores pre and post DePART intervention, comparing calendar years. The percentage of “very good” scores for the overall patient satisfaction (63.5-78.4%) showed a statistically significant improvement ($p<.01$) (Knier, et al., 2014).

The DePART discharge process encompasses several of the elements found in this study. Although many elements are specific to the rehabilitation setting, many were identified in this study process such as: identification of a discharge date, the timely obtainment of physician orders, engaging the patient and family with a check list in order to clarify expectations after discharge, and the follow up phone calls. This supports the participants constructs identified as either positive or negative factors influencing their overall hospital stay.

A study in Iran showed 45% of their patients were dissatisfied with the length of the discharge process (Ajami & Ketabi, 2007). The delay with discharge of a patient not only increases dissatisfaction with the inpatients, but it creates a delay for the admission of any new patients for the facility. A timely, thorough, and collaborative discharge is an essential element in the overall satisfaction of the patient experience and a major influence on their overall rating of their hospital stay.

Key Drivers

Data were analyzed in stages from the Ajjawi and Higgs model (2007). The analysis began looking for emerging constructs in the second stage, *understanding*, and then grouping into sub-themes in stage three, *abstraction*. Next in stage four, *synthesis and theme development*, the sub-themes were grouped into themes. Finally in stage five, *illumination and illustration*, descriptive participant statements were provided reflective of that theme. Links of the themes to literature were provided.

The participants were asked what factors, if any, influenced their overall rating of their hospital stay. These became the major constructs of the *understanding* stage. These first line constructs included; physicians, discharge, follow up after discharge, education, patient rooms (including size and roommates), other staff members and interactions, staff, responsiveness of the staff to the patient needs, history of the hospital, technology of the equipment, outcomes of treatment and diagnosis, skill of the staff, food, personal accommodations individualized to the patient, personalized care, communication (verbal and non-verbal), personal hygiene, interactions with staff, and caring. These items were later constructed into the four major themes identified: human interactions, caring behaviors, hospital accommodations and procedures, and transition to home.

Nurses have been found to be a major influencing factor in a patient's level of overall satisfaction while hospitalized in the acute care setting (Abramowitz et al., 1987). The study found nursing care was the only service related to overall satisfaction with hospital stay. The improvement in nursing care was found to be the most effective manner for enhancing patient overall satisfaction, ($r^2=0.66$) (Otani & Kurz, 2004). The results of this study reinforces the value patients have on the perception of "caring" staff. The study found the participants had more detailed and, in general, more mention of physicians in the interviews. However there were several exemplars, both positive and negative, that were specific to bedside staff. Although, it is essential to know the generalization that is typical of the public regarding staff members and their roles in a hospital. There are several different disciplines that might interact with a patient during a hospitalization; it is not unusual for the patient to label all staff as "nurses." In this study, it is not possible to decipher the true identity of those noted as nurses by the participants. However, it is important to understand the work environment in which the nurses live because the factors that influence the patient's level of satisfaction must be framed within the context of the environment. Based on the sub-themes and themes formed from the transcripts, there is not only an understanding of the work environment, but also the cognitive working of the nurse and their communication.

Limitations of the Study

There are a number of limitations associated with this study:

- The study findings cannot be generalized to all acute care patients. The sample was selected from returned surveys that met the study criteria for inclusion. The results may only represent the lived experiences of the participants.

- The participants may have hidden certain aspects of their experience and thus the ensuing transcript may not have represented their entire experience.
- The participants described their perceptions of the events. There is always the possibility that the reported behaviors and interactions may differ from their actual behaviors and/or events.
- The telephone interviews were semi-structured, using predetermined questions so that responses also were structured, to some degree, by the researcher. While most of the questions were open ended, some aspects of the patient experience may not have been revealed.
- The unsuccessful attempt to establish focus groups forced the researcher to complete the study with telephone interviews. The researcher lost the ability to establish field notes on the participants non-verbal distinguishes and communication.
- The length of time from the participants' hospitalization, time of survey completion and return, and the researcher telephone interview, is also a limitation of this study. The discharge dates were as far back as September 1, 2013 with the most recent being October 3, 2013. The telephone interviews were conducted March 2014, allowing a maximum of six months from the date of discharge. The length of time might diffuse the patients detailed recalled of their hospitalization.
- The survey was only conducted with English speaking participants.

Implications

This study has relevance for creating a better clinical environment for patients in the acute care setting. The findings demonstrate the importance placed on the human interactions and relationships that are typically negotiated when faced with competing

priorities in this setting. The importance of this study is it was conducted with the patients themselves, capturing their lived experience from their perspective. The findings from the study highlight there are number of key drivers patients consider when assigning a numerical value to the overall rating of their hospital stay. There are also contributing factors that influence and direct some of those key factors, specifically the human interaction construct. There is no simple solution to address the issues that contribute to a hospital falling short of a patient's expectations of their patient experience. The findings will enable health care providers to better anticipate the needs and expectations of their patients. This study has illuminated themes in regards to the work environment and communication. However, study results have several implications into the clinical practice, nursing and hospital leadership, as well as nursing education.

Clinical Practice

Patient satisfaction is not only important because of the reimbursement dollars, in fact, poor self-reported experiences with health care systems are associated with slower recovery from illness and a lower likelihood of adherence to prescribed treatment regimens (Chatterjee et al., 2012). Patients with high satisfaction scores reported greater adherence to discharge orders (Lynn, McMillen, & Sidani, 2007). Clinical practice should include educating patients on the discharge process and clarifying expectations, as well as performing the discharge in a timely manner. A low perceived readiness for discharge was found to be a strong predictor of difficulty coping and readmission after discharge (Knier et al., 2014, p. 38).

Nurses are the chief care providers for patients throughout hospitalization, spending the majority of their time at the bedside; nurses are the public face of health

care. An engaged workforce with patient-focused care provides positive benefits for the patient, the hospital, and fulfillment for the nurse. Bacon and Mark (2009) found that nurses who work on units with higher levels of support services for nursing and with greater work engagement were more likely to be satisfied with the quality of nursing care delivered.

Nursing and Hospital Leadership

The patient experience is recognized and solicited as a means of assessing healthcare delivery and a method of gauging patient centeredness (Edwards et al., 2014). Many healthcare facilities use this as a quality measure, as well as a means of publication of such data and benchmarking. A positive and improving patient experience has many benefits such as reduced lengths of stay, improved outcomes, cost reductions, and increased patient loyalty. Welch (2012) reports caregivers who work within a system delivering positive customer satisfaction experiences have fewer malpractice suits than those who do not have such an environment. By providing focused education on the patients' key drivers, the patients will be more satisfied and this will reflect on the HCAHPS survey, allowing for optimal reimbursement. The information obtained in this research study will allow the healthcare providers to focus on the expectations of the patients and the community in which they exist.

Identifying the key drivers patients consider when assigning an overall rating to the hospital will allow the facility to customize the approach to patient satisfaction, instead of using a blanket and standardized approach; an approach that might not even be applicable to the facility or patient population. The patient's perspective is considered a

major measure of quality and a facility's ability to meet the patient's expectations and needs (Holzer & Minder, 2011).

In 2009, Press-Ganey noted a hospital's top five priorities must include a focus on empowering staff to "effectively communicate information and empathy to their patients" (Lauer & Beryle Institute, 2009, p.4). Aiken et al., (2012), showed investments in better nurse staffing improved patient outcomes only if hospitals also had a good work environment. In addition to better staffing, supporting best practices (i.e., Magnet recognition), improved patient outcomes. The quantity of staff is not representative of the quality of the professional work environment, nor the care that will be rendered. In several of the most positive exemplars, the participants described interactions that would have taken considerable time for staff to be engaged in. The lack of staff would have presumably made that time with the patients less likely to have occurred.

The reputation of the provider, as well as that of the healthcare organization, has been identified as the most influential factor consumers consider when selecting a provider. Hospital administrators must facilitate management of the referral sources (physicians) to ensure they consistently meet their needs. The excellent service and care to both existing patients and to the network of referring physicians is essential to ensure the attraction of new patients (Abraham, et al., 2011). In addition the same study found few respondents identified advertisement or formal sources of quality information affected their decision of choosing a provider.

Healthcare administrators must also be aware of the contributing variability influencing the patient experience. Administrators must understand the essence of the data, as well as their patient population, to fully benefit from changes toward improving

the patient experience. A study by Holzer and Minder (2011) showed the difference in patient experience scores appeared to occur mainly at the patient level and to a lesser extent at the process and hospital levels. The study used the Picker Problem Score (PPS) to measure the patient experience in six domains (Pickering Institute, 2013). The domains included; care, communication, respect, cooperation, organization, and discharge management. The study supported previous data indicating patient factors are the strongest predictors influencing patient experience score, not hospital factors. The patient factors included self-reported health, age, and education. Age was seen as an important modifier of satisfaction and the age variable should be considered as a non-linear factor for adjusting patient satisfaction scores. Another study found patients younger than 40 and older than 70 reported more problems with their hospitalization care than middle-aged patients (Moret et al., 2007).

In addition to age, Holzer and Minder (2011) also found the mode of admit and service department had an affect the patient experience. Patients admitted through the Emergency Department were less satisfied than patients with a planned admission. The study also found variation based on the service department. Patients in gynecology departments (excluding women with childbirth) tended to have lower patient experience measures. This study supported the data of the Mode Experiment conducted by CMS in 2008 regarding mode and patient mix adjustment. The Mode Experiment also found Emergency Room admits generally have lower HCAHPS scores.

The HCAHPS Mode Experiment, 2008 resulted in adjustments applied in a possible three areas of the HCAHPS survey data. The first area adjusted for is the survey mode; hospitals may choose one of four modes of data collection. These survey modes

include, mail, telephone, mixed mode (mail combined with telephone follow up), or active interactive voice response (IVR). The second adjustment is made for the patient mix adjustment. The patient mix adjustment (PMA) is adjusted for patient characteristics that are not under the control of the hospital, such as age and education. The third area is nonresponse bias, however this is only adjusted if three factors are present: 1) non-respondents differ from respondents, 2) non-respondents and respondents differ in ways that are related to how patients evaluate hospitals using HCAHPS, and 3) these differences persist even after adjusting for the survey mode and patient mix. If all three factors are present, then the survey will be adjusted for nonresponse bias. It is because of the variation noted CMS developed these three adjustments to create a more equal comparison across hospitals, regardless of the patient factors and the survey mode.

The patient experience is a reflection of what actually happens during the care process and provides information about the performance of healthcare workers (Kieft et al., 2014). Hospital administrators should use the patient experience as an indicator for evaluating and improving the quality of care delivered by their facilities. In addition, it should be considered to direct quality and process improvement projects both as an individual provider and as an institution.

In a study across four Emergency Departments, the practice of caring behaviors showed a strong correlation with patient loyalty. The specific behaviors identified were making sure the patient is aware of care-related details, working with a caring touch, and making the treatment procedure clearly understood by the patient (Liu et al., 2010). In the competitive market of healthcare today, patient loyalty should be one of a hospital administrator's main focuses.

Nursing Education

Nursing education can be targeted uniquely to facilitate the staff and the hospital meeting the expectations of the patients. Nursing schools should consider further academics in regards to the subjective task of nursing and the emotional needs of the patients. Nursing education should embrace and educate in regards to patient satisfaction and customer service, considering the financial impact and the relevance to nurses and hospital alike. Not only should the staff be educated on patient satisfaction, it is imperative patients are educated on their expectations of hospitalization. As indicated in this study, several patients noted a lack of comparison for rating their overall hospital experience. In order to achieve patient satisfaction in the ever-changing world of healthcare, it is essential that we manage the expectations of the patients. Edwards et al. (2014) identified expectation, outcome, and time as modifying the perception of the hospital experience for patients and families. Both the patient and family reported assumptions and expectations shaped their experience. Patients and family members would benefit from a “what to expect” tutorial either prior to admission or directly upon admission. By setting up clear realistic expectations, you are creating an informed consumer with a clear understanding of the hospitalization process.

Caring is an essential and highly valued aspect of nursing care, for both nurses and patients. As evidenced in this study, patients hold in high regard caring behaviors, and consider it a major influence of the rating of their overall patient stay. However caring behaviors is not a routinely documented item in the patient record. Brenner, Dimitroff, and Nichols (2010) found the awareness of caring is increased by the act of documentation. The qualitative data analysis from the focus groups revealed three

themes including increased awareness, caring behaviors not evident, and preferred format. The documentation of caring behaviors increased the awareness of what nurses do, and it reinforced the realization that caring behaviors are not evident in the patient's medical record (Brenner et al., 2010). The practice of documenting the caring behaviors, so valued by both patients and families, should be considered for implementation.

There are variations in not only the patient experience, but the defining and perceptions of caring behaviors, as evidence of the study by Papastavrou et al. (2011). A recommended focus for education would be of cultural diversity and defining patient experience within the specific cultures.

There is a gap, supported by research, that clearly notes the differences in patients' and families' definitions and expectations of the patient experience, than what the providers feel the patients' expectations are (Holzer & Minder, 2011). When providers were asked to define the hospital experience for a patient for whom they had cared, the answers included:

“Caring attitude, the communication with the patient, being treated with dignity and respect, the physical structure, cleanliness, courteousness, and attentiveness of the staff. Nursing staff, the doctors and their skills, their attitude, the environment, the building, the food. The care they received, the information, how the patient viewed their time while they were in the hospital. Whether he feels he is getting better or not improving. How the patient experience their stay. The people the patient came across.”

When the patient was asked what mattered most in his hospital experience he stated,

“The operation, people, and family.” His wife stated what mattered most to her was that

her husband's operation happened. However when analyzing the interviews of this study, the themes that emerged as most important to the patient and family were medication management, physical comfort, and emotional security. Regardless of the variation in the specific verses direct question responses, it is clear that the patient experience is defined differently for recipients and providers of healthcare. The healthcare providers delivering the care are not always aware of what matters most to the patients and their families.

Recommendations for Future Nursing Research

The concept of patient satisfaction is being investigated now more than ever. This study specifically targeted the key factors patients considered when assigning an overall rating to their hospital stay. Future studies should focus on the qualitative approach in order to dive into and explore the quantitative data currently available. In this study the one participant noted a delay in responsiveness from the nurse, but she was very dismissive of this because "I know they are busy." Situations such as this might appear as a negative remark if completed in a quantitative manner, however given the opportunity to explore the patients' feelings behind the lack of responsiveness, provided the researcher with a completely different construct. The researcher was then able to explore the relationship that existed between the patient and the nurse. Patient satisfaction is merely a perception of expectations, and is limited in a quantitative research design. This study has opportunity for future research studies that include other potential influences to the patient's scoring of their overall patient experience, such as the patients' proximity to the hospital location. In addition, in the future, the study should include a comparison of the participants scoring of the overall rating question on their initial HCAHPS survey, and their comments in the current study. Finally a future study

should include identification of key drivers distinguishing those patients rating the overall hospital experience as a “9” or “10” on the HCAHPS survey compared to those patients scoring the hospital as an “8.”

Future research considerations should involve further assessment of the variables within the patient sample, such as the patient’s ethnic background and culture, as well as the diagnosis of the participants. Study considerations may include chronic verses acute illnesses, as well as prognosis. Further analysis is needed regarding the hospital unit, as well as the specific work environment, including nursing characteristics of the department that can be combined with the rich, qualitative data already obtained.

Conclusion

This study to explore the key drivers influencing the patient’s overall rating of their hospital stay was undertaken to discover and explore the phenomenon and share a better understanding with others. Patient satisfaction is a subjective perception of the patient that may or may not be based on previous knowledge. As this study demonstrates in the identification of the key drivers, the patient experience is a complex multifaceted and individualized experience. The study demonstrates the many contextual factors that influence the patient perception of the situation, the surrounding, and that of the individual interactions. There are personal, environmental, and situational factors unique to each patient and each experience. The uniqueness of each situation is grounded in the patient’s lived experience that emerged in this study. Qualitative research *believes* no single reality exists and such the goal here is not to find absolute “truth” of the hospital experience but rather to compare multiple realities as based upon various perceptions

(Milne & Oberle, 2005). The impact of a single interaction holds stature far beyond a technical task; it is inclusive of the human touch that completes the task.

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Appendix A

Telephone Recruitment Script

Sample of Telephone Script for Participants to be used for Recruitment in the Study:

The patient experience: An exploration of the ratings from the consumers' perspectives

A research study is being conducted by Barbara Kelley, a doctoral student at the University of San Diego. The purpose of this study is to gain a better understanding of the patient experience from patients themselves. I hope to improve the education and training provided to staff in order to improve the patient experience.

1. Would you be willing and able to attend a one hour focus group on Thursday evening or Saturday morning at Scripps Mercy Hospital, the San Diego campus?
2. If unable or unwilling to attend either of the focus groups, would you be willing to participate in a brief telephone discussion. We can complete the brief interview now or can schedule a time that is more convenient for you. Our conversation will be recorded and will take approximately fifteen minutes.
3. The interview will be to discuss your patient experience during your hospitalization at Scripps Mercy Hospital.
4. The interview will be recorded in order to capture each detail of our conversation.
5. Your identity and confidentiality will remain protected in the recordings, notes, transcripts, and in the study itself.
6. If the reply is “yes”, then the researcher will continue on with the consent process.
7. If the reply is “no”, the researcher will “Thank” the potential participant for their time.

Appendix B

Consent Form

A research study is being conducted by Barbara Kelley, a doctoral student at the University of San Diego.

Personal introduction

- Hello my name is Barbara Kelley
- I am a Doctoral student at the University of San Diego in the School of Nursing
- I am contacting you because we are doing a study about patient satisfaction and our records indicate that you have been in the hospital within the last six months at Scripps Mercy Hospital.
- Would you be willing and able to attend a one hour focus group on Thursday evening or Saturday morning at Scripps Mercy Hospital, San Diego?
- If not would you be willing to participate in a brief telephone discussion. We can speak now or we can schedule a time that I may call back. The conversation would be recorded and will take approximately fifteen minutes.

Consent to Record

In order to capture our conversation, I will be recording it. I need your permission to do so, I would like to start the audio recorder and have you verify with a “yes” when I ask you for consent from you to audio record our conversation.

Your participation in this study is:

Voluntary

You do not have to do any of this. Nothing about your access to health or social services will change if you decide not to do this. You can decide to quit at any time.

Confidential

No names will be recorded on audiotape or attached to the survey form. All consent forms will be stored separately from data. Only code numbers will be used while recording the discussion. What you say in the discussion will be transcribed (written into a document). A transcriptionist (a person who types your words while listening to your audio recordings) from a third party adheres to confidentiality in the transcribing of the interviews. All data, including audiotapes, will be kept in a locked file cabinet and only the researcher will have access. She will keep all the completed data at least 5 years before destroying them. The results will be reported on a group basis, and your identity will never be identified in reporting the results. The results of the research project may be

made public and information quoted in professional journals or meetings, but your real name will never be used

Potential Risks.

If you become tired while filling out the form or participating in the focus group, you can take a break to rest. Sometimes when patients are asked to reflect on their patient experience, they feel emotions like anxiety. If you would like to discuss these feelings, you can call the **San Diego County Mental Health Hotline (1-800-479-3339), anytime, 24 hours a day.**

Benefits.

The benefit to participating will be in knowing that you helped other patients and other healthcare providers know more about the factors affecting the patient experience.

Participant Costs.

The only cost to you is the time you spend traveling to and participating in the focus group. If you elect to complete a telephone interview there will be no cost incurred.

Further Information.

If you would like to know more about this research study—before, during, or after your participation in it—you can e-mail Barbara Kelley at Kelley.barbara@scrippshealth.org.

Signature of Participant

Date

(Printed name of Participant)

Signature of Investigator

Date

Appendix C

Telephone Interview Guide

The patient experience: An exploration of the ratings from the consumer's perspectives

Hi, my name is Barbara Kelley. You can call me Barbara. I am a doctorate student at the University of San Diego, School of Nursing. I also work at Scripps Mercy Hospital.

The patient experience is very important in health care today. The interactions and experiences patients have in the hospital are translated by the patient on the patient satisfaction tool that is used consistently across the United States. Healthcare has and continues to invest a substantial amount of money and manpower towards meeting the expectations of patients. There has been an abundance of research investigating patient satisfaction. However there has been little information from the patients. Specifically in relation to what determines how patients rate their overall hospital experience on a scale from 0-10. This specific survey question is the specific interest of this study. As well as what determines the number rating that patients assigns to rate their overall hospital experience. Please tell me about your considerations and recall of what your thought process in answering this survey question. In other words, what type or specific things influenced you, or what that you were thinking about, when you assigned the number value to this specific question.

The specific questions included:

1. Do you recall receiving the satisfaction survey after your inpatient hospital stay?
2. Do you remember the question asking, "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?"
3. Can you remember and tell me about some of the events or conditions that influenced what number you gave the hospital on this question?
4. Were there specific incidents or events that you recalled when answering this question?
5. Can you think of anything else you would like to discuss in regards to your patient experience?

When above completed:

6. When all questions have been discussed, researcher then will ask for permission to ask a few demographic questions. If no objections from the participant, then the researcher will ask the demographic questions (See Appendix E).

Upon completion of the demographic survey. The researcher closes the session.

7. “Thank you for taking the time to participate in the study. I would like to “Thank you” very much for helping me by providing your insight.
8. Researcher stops the recorder.

Appendix D

Demographic Information Form

The patient experience: An exploration of the ratings from the consumers' perspectives

Instructions: Please complete at the conclusion of each interview.

1. Age: _____
2. Gender: _____
3. Marital Status:
 - a. Single
 - b. Married
 - c. Widowed
 - d. Divorced
4. How did you enter the hospital?
 - a. Emergency Department
 - b. Direct Admission
 - c. Planned Surgical Admission
 - d. Transfer from another hospital or facility
5. Number of hospitalization in the past 2 year: _____
6. Zip Code: _____

Appendix E
Initial Screening and Notes Tool

- 1). Date/Time _____
- 2). Pt ID _____
- 3). Can you attend a focus group? Yes _____ No _____
A. Schedule Availability _____
- If NO, then go to #4
- 4). Would you be interested in doing a brief phone interview?
Yes _____ No _____
- 5). Recorded consent _____ Time _____
Recorder on _____
- 6). Key Points _____

- 7). Thank You

Appendix F

University of San Diego IRB Exempt Status Form

ENTERED
2/19/14

Institutional Review Board Project Action Summary

Action Date: February 19, 2014

Note: Approval expires one year after this date.

Type: ☐ New Full Review ☐ New Expedited Review ☐ Continuation Review ☒ Exempt Review
☐ Modification

Action: ☒ Approved ☐ Approved Pending Modification ☐ Not Approved

Project Number: 2014-02-168

Researcher(s): Barbara Kelley Doc SON
Dr. Linda Urden Fac SON

Project Title: The patient experience: An exploration of the ratings from the consumers' perspectives

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

Modifications Required or Reasons for Non-Approval

None

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit a project proposal for expedited review at any time.

Dr. Thomas R. Herrinton
Administrator, Institutional Review Board
University of San Diego
herrinton@san Diego.edu
5998 Alcalá Park
San Diego, California 92110-2492

Office of the Executive Vice President and Provost
Hughes Administration Center, Room 214
5998 Alcalá Park, San Diego, CA 92110-2492
Phone (619) 260-4553 • Fax (619) 260-2210 • www.sandiego.edu

SIGNATURE PAGE

All applicable signature lines MUST be signed. If any required lines are left blank, the application will be returned to the principal investigator.

Barbara Kelley LI(vt.t.:M J'St>.A -f q O d- \ 3).')<>\
 Researcher (signature) Department/School and Date

Barbara Kelley bcamrn73@yahoo.com _619-726-6653_
 Researcher (printed) REQUIRED: email Phone

d;:,t §JZlulk J.-13-/J/
 Faculty Advisor (signature) Department/School and Date
 (Only required if PI is a USD Student.)

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 Faculty Advisor name (printed) REQUIRE6: email Phone

f114
 USD Sponsor (signature) email Phone
 (Only required if PI is NOT a USD student/faculty. The USD sponsor must be a full-time employee of USD).

USA
 USD Sponsor name (printed) Department/School and Date

John M. G... .2 /13/Jt-(
 School/College Representative Date
 (All applications must obtain this signature, whether your unit has a designated IRB representative or not. Contact the IRB Chairperson if you need guidance.)

-911 'tWt-, -fIP, Cliff" W ;)(13/11f
 Dean or His/Her Representative (signature) Date

The project described above has been approved by the USD Institutional Review Board.

JL 1-/1/1y
 Chair or Administrator to IRB (signature) Date

UNIVERSITY OF SAN DIEGO
Institutional Review Board (IRB)
APPLICATION FOR EXEMPT STATUS ONLY

This form is only to be used only when applying for **EXEMPT** status from IRB review. Please check the examples of Exempt applications on the USO /RB website.

Go to:

<http://www.hhs.gov/ohrp/humansubjects/quickstart/45cfr46.html#46.101%28b%29>

under **Part (b)** to view descriptions of expedited research category numbers (1) through (6). You **must** check **ONE** space below for the category number below that applies to your project. For example, many projects involving educational practices fall under category (1).

 (1) Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

 (2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:

(i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

 (3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (2) of this section, if:

(i) the human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

 X **(4)** Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

 (5) Research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine:

(i) Public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs.

 (6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

TITLE OF PROJECT: "The patient experience: An exploration of the ratings from the consumers' perspectives.

PRINCIPAL INVESTIGATOR: Barbara Kelley
School/College: PhD student, Hahn School of Nursing and Health Science

FACULTY ADVISOR (if USO Student): Dr. Linda Urden
School/College: Faculty, Hahn School of Nursing and Health Science

USO SPONSOR (if PI is not a USO faculty/student): N/A
School/College:

RESEARCH ASSISTANTS: N/A

Does this project require institutional permission or IRB approval from other institutions? ☒ Yes ☐ No

If applicable, please name the institution here: Scripps Mercy Hospital

- If applicable, please ATTACH either a letter of permission or a copy of the IRB approval as an appendix.
- Please ATTACH a copy of an RB training certificate for everyone named above.

In the space below, BRIEFLY describe the project and *the way in which it meets the category number* you checked on page 1. Describe data or information to be obtained and its source. If applicable, please attach any text that participants will see, including emails, surveys, consents/assents, etc.

Purpose: To evaluate a set of pre-existing data on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys to identify key drivers influencing patients' ratings of their overall hospital experience reflected on the HCAHPS survey.

Rationale for Category 4: Data is pre-existing in consumer completed HCAHPS surveys received between the months of September, October, and November 2013, post discharge after an inpatient stay.

Data to be Obtained: (List your data here, following this example:)

1. Name
 2. Age
 3. Gender
 4. Desire to be contacted
 5. Phone number
 6. Zip code
 7. Days in hospital
 8. Discharge date
 9. Unit
 10. Language of survey
 11. DRG code
 12. Rating, (coded by Press Ganey noted as: positive, negative, or mixed)
-

3

- 13. Survey results on all questions
- 14. Participant's comments
- 15. Survey received date
- 16. Specialty (of the unit applicable)