2015-5

Patients' Perception of Feeling Known by Their Nurses and the Nurse Practice Envrionment

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Patients' Perception of Feeling Known by Their Nurses and the Nurse Practice Environment

By

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A dissertation presented to the

FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE

UNIVERSITY OF SAN DIEGO

In partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY IN NURSING

May 2015

Dissertation Committee

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Abstract

Healthcare leaders have a responsibility to understand the connection between healthy practice environments and patients' perceptions of care. The purpose of this research was to explore the relationship between the nurses' perception of the practice environment and the patients' perception of feeling known by their nurses.

This descriptive, correlational study used quantitative and qualitative methodology. A convenience sample of 123 patients, on six patient care units, completed the *Patients' Perception of Feeling Known by their Nurses Scale* and a supplemental survey designed to determine the content validity of the *Patients' Perception of Feeling Known by their Nurses Scale.* To measure registered nurse satisfaction at the unit level (N=6), 290 nurses completed the National Database of Nursing Quality Indicators *RN Survey with Job Satisfaction Scales-R.*

Patients' perception of feeling known by their nurses was high with a mean of 3.5 out of 4.0. No significant differences between levels of care were found. Nurses had favorable satisfaction at 4.37 on a 6 point scale. Nesting patients within individual nursing units, mixed linear modeling for the relationship between job satisfaction and patients' perception of feeling known was non-significant ($t(4) = -1.085$, $p > .05$). The supplemental survey offered content validation on the subscales of "Experienced a meaningful, personal connection with their nurses" and "Felt empowered by their nurses to participate in their care." For the subscale "Felt safe" a focus on safety measures was revealed as a new category. The fourth subscale, "Experienced being recognized as a unique human being," suggests nursing has opportunity for improvement in the more subjective aspects of patient care.

Dedication

I dedicate this dissertation to my loving family who has supported me over the last ten years while I have earned two advanced degrees. Without their tireless support, my success would not have been possible. A special thanks to my husband of more than 30 years who has been my partner, my friend, and my staunch advocate in whatever journey I have chosen to follow. Not to mention all the meals he has cooked and special projects he has completed while I have been glued to my computer for hundreds of hours. To my children, Brennen, Kayla, Brett, and Riley, and granddaughter, Scarlet, who have given up Mom and Grandma time so I could fulfill my dream of completing my doctorate degree. I would like to also recognize my late mother and father who instilled in me the value of education and whom I know would be so proud of my accomplishments.

Acknowledgements

I want to start by acknowledging two very important mentors, Dr. Willa Fields and Dr. Ana-Maria Gallo, without their encouragement and support I would not have started my PhD journey. I kiddingly tell people "I blame them" but in reality I am so very grateful for their gentle nudging and confidence in me. I have so much respect for them and owe them great amounts of gratitude.

My heartfelt thanks go to my superior dissertation committee, Dr. Linda Urden, Dr. Ann Mayo, and Dr. Jane Georges. Without this group of smart, dedicated, and knowledgeable researchers guiding and supporting me, my research work would have been so much more difficult. To my chair, Dr. Linda Urden, thank you so much for your guidance in my overall research design, answering my numerous questions, keeping me on track, and editing my work. I could not have done it without you. To Dr. Ann Mayo, you have supported me from the beginning, not only as valuable member of my committee, but as an instructor, and as my faculty mentor. I have learned so much from you and I cannot thank you enough for the many hours you spent editing my work and advising me. Dr. Jane Georges gave me my first glimpse of scholarly thinking in her Nursing Philosophy course; I truly admire her incredible knowledge and understanding of these important foundations of our profession. Thank you, I am honored to have had your input and support on my committee.

To Dr. Sally Hardin, Dean of the Hahn School of Nursing and Health Science, thank you for your financial support through the University Graduate Deans' Scholarship

program. I appreciate your confidence in me and the faculty mentorship I received through this opportunity.

To my work-associated classmates, Carmen Colombo, Verna Sitzer, and Belinda Toole, what a great team we were, and I so appreciate the ongoing support, comradery, and dedication to our journey together. Thank you so much for always being there for me and each other, it made all the difference in the world. I would be remiss not to recognize my employer of more than 30 years, Sharp HealthCare and its leadership. I owe a debt of gratitude for not only the financial support through educational reimbursement and scholarships, but time away from the work place to attend class and complete my degree. The knowledge I have gained is returned daily through my work and dedication to this exceptional organization.

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Chapter I

Introduction

After the Institute of Medicine's (IOM) publication of *To Err is Human: Building a Safer Health System* in 1999, there was a swift and positive response from policy makers, healthcare organizations and researchers (Kohn, Corrigan, & Donaldson, 2000). In 2001, the IOM published a follow up report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, to broadly and strategically address quality-related issues and to provide direction for the redesign of the healthcare delivery systems (IOM, 2001). Broadly, this report proposes six aims for improvement, specifying healthcare should be safe, effective, patient-centered, timely, efficient, and equitable (IOM, 2001). More recently, the Patient Protection and Affordable Care Act of 2010 required the Health and Human Services Secretary to institute a National Quality Strategy to "improve the delivery of health care services, patient health outcomes, and population health" (US Department of Health and Human Services, 2010). This strategy established three aims and six priorities for improving the overall quality of health care. The aims, better care, healthy people and communities, and affordable care, are supported by the six priorities. Two of the priorities addressed safer care by reducing harm in the delivery of care and

ensuring each person is engaged as partners in their care (US Department of Health and Human Services, 2010). With increasing regulation and patient advocacy groups mandating and supporting patient-centered models of care and improved healthcare safety, comes the need for radical change in the models of care delivery and the culture surrounding the delivery of care.

Nurses are well positioned to incorporate patient-centered initiatives to address the need for improved care delivery models. Nurses play a pivotal role in helping patients understand the healthcare experience and communicating their values and beliefs to the healthcare team, but therapeutic relationships must be developed between the nurse and the patient first. However, a key requirement for improvement must be the patients' perception of the healthcare experience. The perception of the patient is a key variable often missing in research completed to date. Historically, providers of care at the bedside, primarily nurses, physicians, and ancillary support personnel, provide care based on personal experience, cultural norms, and basic assumptions of consumer need. In order to improve and change care delivery models, the perceptions of patients regarding their healthcare experience must be explored and investigated. Specific examination of the patients' perception of feeling known by their nurses may advance the nurse-patient relationship and safety during an inpatient hospitalization.

With limited knowledge regarding the influence of the practice environment on the experience of the patient, exploring the patients' perception of feeling known by their nurses in relationship to practice environment characteristics may contribute to the development of care delivery reform. The link between the practice environment and positive patient outcomes has been well researched; however, gaps continue to exist in

understanding the relationship between the practice environment and a climate for patient-centered care (Rathert & May, 2007). Nurses working in empowering and autonomous practice environments may have infrastructure in place to support patient-centered models of care; however additional research is needed to assess these relationships. Measurement of "patients' perceptions of feeling known by their nurses" may offer healthcare providers insight into what patients value during inpatient hospitalizations and how provided care is perceived. This study explored the relationship between the nurses' perception of the practice environment and the patients' perceptions of feeling known by their nurses during an inpatient hospitalization.

Background and Significance

Patient-centered models of care provide opportunity for nurses to establish relationships with the patient and truly know the patient as a person. However, with many competing priorities, nurses and staff at the bedside have difficulty navigating between high priority initiatives and requirements, and providing compassionate patient-centered care. With nurses and staff spending increased time meeting regulations and mandates, time for individualized patient care and the establishment of therapeutic relationships begin to erode. When time focuses change from patient-centered to documentation and requirement-centered, patients and families may begin to express dissatisfaction with the level of care and compassion being delivered (Klinkenberg et al., 2011). These focus changes in care delivery models directly affect the core of nursing professional practice and the fundamental caring model which nursing has traditionally followed. The basic core of nursing work has been supported through the human caring

model of care, with nursing care and compassionate caring the critical variables in the patient's experience (Watson & Foster, 2003).

Patients expect nursing care to be competent, caring, and provided within a patient-centered environment. When patient and family trust and confidence in the healthcare system and in the individual nurse or staff at the bedside is jeopardized, their feelings of safety and security are additionally jeopardized. Establishing trust with patients, and subsequently their family, enhances feelings of safety (Hupcey, 2000; Meriläinen, Kyngäs, & Ala-Kokko, 2010), allows patients to relax (Hawley, 2000), and build relationships with the nurse or health care professional (Calman, 2006). Through the establishment of a therapeutic relationship the nurse is able to enhance the level of patient participation in their care and create opportunity to uniquely know the patient (Henderson, 1997). When nurses provide care to patients, without understanding the patient within the context of his or her life, conflict in healthcare related goals can arise resulting in the patient feeling unsafe. In addition, without the ability to know the patient as a person, care becomes routine and task-driven, which is then potentially perceived by the patient as impersonal and cold.

It is important for nurses to know patients on not only a clinical level but a personal level as well. Knowing the patient enhances patient-centered care and increases the patient's participation in their care. Critical factors necessary for nurses to know their patients include positive nurse-patient attitude, mutual trust and rapport, meaningful interactions and sustained nurse-patient contact (Henderson, 1997). Knowing patients on a personal level requires nurse expertise, confidence, and engagement. With experience, a nurse becomes more skilled at empathizing with the patient and understanding the

patient's perceived reality. Through these perceptions, the nurse is able to plan nursing care which provides higher patient satisfaction and improved patient outcomes (Polifroni & Welch, 1999).

Understanding the patients' perceived perceptions of safety and quality of care is important, but considering what level of involvement and responsibility patients desire in their care and safety is yet another aspect to be considered. Involving patients in a direct role in regards to their care and safety requires patient-centered models of care, in addition to practice environments where staff are empowered to develop the needed relationship with patients (Aujoulat, d'Hoore, & Deccache, 2007; Burroughs et al., 2007; Rathert, Huddleston, & Pak, 2011). The benefit of patient involvement in their care is still in early stages of research; however, the importance of incorporating the patients' perspective cannot be underestimated. Adopting patient-centered care models enhances not only the experience of the patient during the healthcare encounter but the quality and safety of the care they receive (Piper, 2011).

In order to build a patient-centered culture and promote the patients' perception of feeling known, the environment in which nurses and other healthcare providers practice is of critical importance. Increasingly, evidence has supported a relationship between patient outcomes, nurse satisfaction, and healthy practice environments (Rathert & May, 2007, Van Bogaert, Meulemans, Clarke, Vermeyen, & Van de Heyning, 2009). Leadership practices and structures essential for a healthy practice environment include the practice of clinical autonomy, nurse-physician relationships, control of nursing practice, levels of engagement and empowerment, job satisfaction, and a patient-centered culture (Kramer, Schmalenberg, & Maguire, 2010, Van Bogaert et al., 2009). An

abundance of research has been conducted related to specific factors of the practice environment, but research exploring relationships between practice environment factors and patients' perception of feeling known by their nurses is limited. In order to create practice environments focused on improving patient outcomes and patient-centered care, healthcare leaders have a responsibility to develop a sound understanding regarding the relationships between these factors. In 2004, the IOM published its report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*. This report recommended fundamental change to nursing practice environments to assure they are more conducive to patient safety. The IOM specifically addressed creation of trust within the organization, managing the change process, direct involvement of staff in decision making related to work and work flow, and use of knowledge management practices (IOM, 2004). All of these factors potentially have a direct effect on nurses' perceptions of their practice environment, which in turn affect the outcomes of care provided, and the perceptions patients have regarding their care and experience during their hospitalization. Assessment of the environment in which registered nurses (RN's) work and practice through periodic evaluation is important for healthcare leaders in order to address gaps, both real and perceived, in the health of the environment.

The practice environment is influenced by multiple factors, with each factor holding different levels of importance based on individual perspectives and beliefs. Additionally, the practice environment is influenced from both organizational and unit based levels. Job satisfaction with a unit level environment does not necessarily mean satisfaction with the organization in general. Hayes, Bonner, and Pryor (2010) classified job satisfaction factors into three clusters; intra-personal, inter-personal, and extra-

personal, with intra being characteristics brought by self, inter being interactions between the nurse and others, and extra the influence of the organization. Although intra-personal factors impact job satisfaction, the organization has greater opportunity to address inter-personal and extra-personal factors, which include such factors as autonomy, professional relationships, relationships with patients and families, tasks, supervisory support, pay, resources, and job opportunities (Castaneda & Scanlan, 2013; Hayes et al., 2010). Research supports the effect of organizational and unit based factors on the ability of nurses to provide individualized patient-centered care and know their patients (Suhonen, Välimäki, & Lenino-Kilpi, 2009). With nurses' perception of the practice environment in which they work being influenced by their job satisfaction, it is important to explore not only levels of satisfaction and overall perceptions of the practice environment, but how these factors are associated with the patients' perception of the therapeutic nurse-patient relationship and feeling known by their nurses.

With the provision of increased technological-supported care in hospital environments comes separation of patients into different levels of care. Historically hospitals provided care at either the Intensive Care or the acute care level. However, with the advancement of technology and medical science comes the ability to care for sicker patients who require more sophisticated nursing care and advanced skills. To support these changes in care needs, hospitals have created additional levels of care and specialty care units within the acute care setting. Regardless of the level of care required to meet the patient's bio-physical needs, the need to receive patient-centered, compassionate care remains the same. Since patients in higher levels of care require more intensive monitoring and task-based care, the ability to build a therapeutic

relationship and truly know the patients is potentially diminished. However, the individualized style and ability of each nurse is a critical component in the extent care is provided from a compassionate, patient-centered focus. The literature addresses the barriers to building therapeutic relationships and connecting with individual patients while in intensive care settings (Crocker & Scholes, 2009; Vouzavali et al., 2011), however, little research has addressed the difference between acute care and progressive care (step down) levels of care. This study investigated whether there is a difference in patients' perception of feeling known by their nurses based on level of care.

Conceptual Framework

Understanding how the practice environment influences the nurse's ability to develop therapeutic nurse-patient relationships, and how these relationships impact the patients' perception of feeling known ultimately affects the patients' experience of care and the outcomes from the care provided. This study was informed by a conceptual framework of the patients' experience of care through the development of a therapeutic nurse-patient relationship and was supported by an adapted version of Duffy and Hoskins' (2003) Quality-Caring Model©.

The Quality-Caring Model© links conceptually and theoretically Watson's (1985) human caring paradigm with Donabedian's (1966) structure, process, and outcome paradigm, providing a mid-range model for clinical practice and research application. Relationships with patients are the core of nurses' work, and specific attributes are necessary for a therapeutic nurse-patient relationship to occur. Watson's Theory of Human Caring theorizes outcomes from caring relationships benefit patients through preservation of human dignity, protection from harm, inner harmony, self-knowledge,

and overall health (Watson, 1985). These interactive, caring relationships are grounded in clinical caring which incorporate interaction (being with), physical work (doing), and relationship (knowing) (Duffy & Hoskins, 2003). Donabedian's structure-process-outcomes health model is blended with the Human Caring Model to form the Quality-Caring Model©. The structural component represents the setting where care takes place (facilities, patients, health care providers); the process represents the delivery of care or specific interventions; the outcomes are the results of the processes put into place (Donabedian, 1966). The structure influences the process of care and the process may directly affect the outcomes of care provided.

The first component in the Quality-Caring Model© is *structure*, which includes the patient/family, provider, and system (participants) under the construct of casual past (Duffy & Hoskins, 2003). Casual past are factors present in the participants before the delivery of care, such as unique attributes, demographics, and experiences (Duffy & Hoskins, 2003). The second component, *process*, is the primary focus of the model and includes the professional encounters, actual interventions, and relationship-centered interactions health care professionals provide (Duffy & Hoskins, 2003). Within the caring relationships component (process), there are two types of relationships: independent (discipline-specific) and collaborative (multidisciplinary) (Duffy & Hoskins, 2003). Independent relationships are the relationships nurses share with the patient and the family which includes attitudes, values, and the facilitation of nursing interventions, while collaborative relationships are related to responsibilities, and interventions nurses share with other disciplines (Duffy & Hoskins, 2003). Thus the caring relationship with patients is three dimensional with the patient, nurse, and other multidisciplinary team

members working both independently and collaboratively to contribute to quality patient outcomes (Duffy & Hoskins, 2003). The caring processes are the foundation of the relationship which creates the human connection based on respect, trust, and sensitivity. This relationship leads to the patients feeling "cared for" which develops a sense of security and improves patient outcomes (Duffy & Hoskins, 2003). The third component of the Quality-Caring Model©, *outcomes*, refers to the results of the health care intervention. There are two forms of outcomes: intermediate and terminal (Duffy & Hoskins, 2003). Intermediate outcomes are the outcomes desired during and by the end of the encounter and include feelings about the process. Terminal outcomes are results that affect the future: quality of life, satisfaction with care, health care costs (Duffy & Hoskins, 2003).

The relationship-centered focus of the Quality-Caring Model© preserves the caring features associated with the professional nurse. Relationships based on caring contribute to positive health care outcomes and incorporate the phases of knowing, connection, and interaction (Duffy, 2003). Through interaction with the patient, the nurse develops a connection which is a precursor to knowing (Duffy, 2003). This connection creates a sense of security which leaves the patient feeling safe and cared for. Creating a caring relationship with the patient generates a knowing of the other which allows the nurse to better assure safety of the patient, decrease patient stress, and improve the patient's satisfaction with care (Duffy, 2003).

An adapted version of the Quality-Caring Model© has been developed to support this study (Figure 1). Under the structure component is the patient and the nurse, reflecting the causal past factors of unique attributes, demographics, and for the nurse

attitudes and behaviors. The process component's primary focus is on the therapeutic, discipline-specific, independent relationship between the patient and the nurse. Lastly, in the third component, outcomes, the study variables of the patients' experience of care (perception) and the nurse practice environment perception and job satisfaction are included.

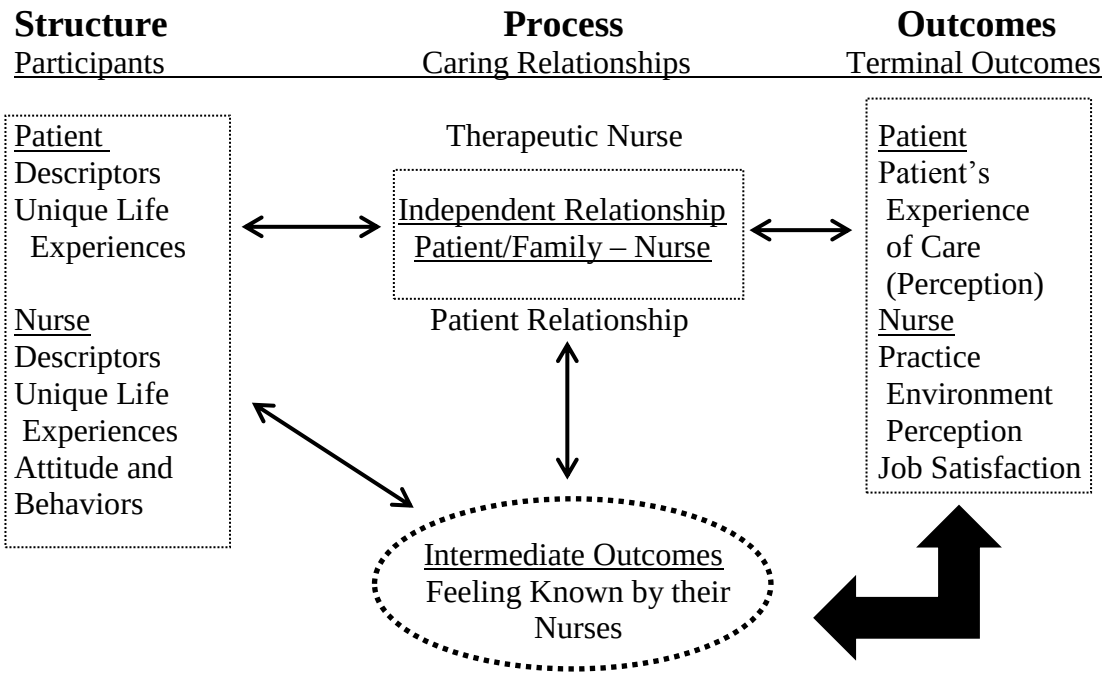

Figure 1: Adapted Quality-Caring Model© (Duffy, 2009)

Purpose and Objectives

The purpose of this descriptive, correlational study was to explore the relationship between the nurses' perception of the practice environment and the patients' perception of feeling known by their nurses during an inpatient hospitalization. Although the practice environment has been well researched, research gaps exist in understanding the link between practice environments and patients' perceptions of feeling known by their nurses.

The phenomenon of knowing has thematically been demonstrated in literature, particularly through qualitative methods of research (Crocker & Scholes, 2009; Henderson, 1997; Henneman et al., 2010; Jenks, 1993). However, there is limited research specifically exploring the patients' perception of feeling known by their nurses, with only the one quantitative study conducted to psychometrically validate the instrument *Patients' Perception of Feeling Known by Their Nurses Scale* (Somerville, 2009a). In order to further explore the phenomena of feeling known from the patients' perspective, this study used quantitative and qualitative methods to obtain complementary but different data regarding the patients' perception of feeling known by their nurse. There is value to collecting additional qualitative data, specifically addressing each subscale of the instrument (felt safe, meaningful connection, participate in care, and unique human being), so complete understanding of the phenomenon can occur.

Research Questions

This research focused on two specific variables, the nurses' perception of their practice environment and the phenomena of feeling known by their nurses from the patients' perspective. The following research questions were addressed:

1. What is the relationship between the patients' perception of feeling known by their nurses and
    a. The nurses' perception of the practice environment?
    b. Patients' level of care (acute vs. progressive)?
2. Is there a difference in patients' perception of feeling known by their nurses based on level of care (acute and progressive)?

3. Are any demographic variables (age, race, gender, marital status, educational level, and days in the hospital) associated with patients' perception of feeling known by their nurses?
4. If any demographic variables are significantly associated, do these variables account for a significant amount of variance in the patients' perception of feeling known by their nurses?
5. How do hospitalized inpatients describe their feelings of safety, connection with the staff, feeling cared for, and inclusion in their care?
6. To what extent does the patients' perception of feeling known by their nurses agree with the data from the open-ended questions on the patients' perceptions of safety, connection, caring and inclusion in care?

Research Aims

The following aims addressed these research questions:

1. Examine the concept "feeling safe" through a concept analysis procedure.
2. To describe the relationship between the patients' perception of feeling known by their nurses during their inpatient hospitalization and
    a. the nurses' perception of their practice environment
    b. the patients' level of care (acute or progressive).
3. To describe the differences in the patients' perception of feeling known by their nurses by level of care.
4. To describe the relationship between patients' perception of feeling known by their nurses and select demographic variables (age, race, gender, marital status, education level, and number or days in the hospital)?

5. To determine which select demographic variables account for a significant amount of variance in the patients' perception of feeling known by their nurses.
6. To further describe patients' perceptions of safety, connection, caring and inclusion through analyses of themes and patterns from data obtained from supplemental questions.
7. To expand understanding of the patients' perception of feeling known by their nurses through validation of *Patients' Perception of Feeling Known by Their Nurses Scale* items with the results of the supplemental questions.

Summary

In summary, this study explored the relationship between the patients' perception of feeling known by their nurses during an inpatient hospitalization and the nurses' practice environment. This chapter has identified the background and significance of patient-centered models of care and their connection to the patients' perception of feeling known. Additionally, the conceptual model supporting this study, research questions, and study aims were reviewed. The next chapter will review the art and science of nursing as well as published literature associated with feeling known from the patient perspective and studies examining the practice environment where care is provided.

Chapter II

Review of the Literature

The purpose of this study is to explore the relationship between the patients' perception of feeling known by their nurses and the nurses' perception of the practice environment. An adapted version of the Quality-Caring Model© developed by Duffy and Hoskins' (2003) was the guiding conceptual model for this study. The Quality-Caring Model© is relationship-centered focus and preserves the caring features associated with the professional nurse. Incorporating the phases of knowing, connection, and interaction, the relationship based caring model contributes to positive patient health outcomes (Duffy, 2003). This section will review the historical aspect of nursing as a caring practice in addition to current research on patient-centered care and the nurse practice environment.

Introduction

Historically, nursing has a foundation in human caring with caring the essence of nursing practice. Ethically, nursing has struggled between human caring models of care and a more medical model of care delivery with an emphasis on task completion, technology, and meeting regulatory and institutional demands (Watson & Foster, 2003).

More recently however, healthcare is beginning to see a movement towards patient-centered models of care with an emphasis on caring-healing environments. For nurses to provide patient-centered care it is imperative they know their patients and this can only be accomplished by developing therapeutic relationships with them. The American Nurses Association Code of Ethics (2001) states that "the nurse in all professional relationships practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual" (p. 6). This professional relationship relies heavily on the nurse knowing the patient, in addition to considering the perceptions of the patient regarding their care during their hospital stay. Through empowered practice environments, nurses will not only be able to provide patient-centered care but improve the safety and outcomes of care provided.

Nursing: Art or Science. Nursing was described as both an art and a science by Florence Nightingale, with the interaction between nurse and client the art, and the empirical or scientific knowledge of nursing the practice (Nightingale, 1863). Over the past several decades, there has been much discussion in the literature as to whether nursing is an art or a science, or a combination of both. The art of nursing has been conceptualized by many scholars to involve the nurse as a professional and a person who provides care through knowledge of the patient (Appleton, 1993). In an effort to explicate the art of nursing, a phenomenology/hermeneutic approach was used to explore both the patients' and nurses' experiences in caring (Appleton, 1993). Five metathemes were expressed including the way of being there in caring, the way of being-with in understanding caring, the way of creating opportunities for fullness of being through caring, a transcendent togetherness, and the context of caring (Appleton, 1993). Each

metatheme is intertwined within each other, whereas one theme cannot exist independently of the other. Both being there in caring and being-with in understanding center on a humanistic perspective of the whole person, including knowing the patient uniquely and connecting with the patient in a caring relationship (Appleton, 1993). Artful nursing is patient and relationship-centered, involves being present for the patient, and being cognizant of patient individual needs so care can be adapted to meet the individual needs of the patient (Finfgeld-Connett, 2008).

Artful nursing practice benefits the patient through enhancement of both physical and emotional well-being. Through the development of a patient-centered relationship, the nurse gains a full understanding of the personal needs of the patient and is able to adapt patient care to meet individual needs of patients (Finfgeld-Connett, 2008). This in turn brings about a unique connection with the patient which creates trust and security within the relationship. In addition, the artful nurse is able to go beyond empirical evidence, making care decisions based on non-analytical ways of knowing (Finfgeld-Connett, 2008). A philosophical investigation of the art of nursing by Johnson (1994) found five senses of nursing art including: grasping meaning in patient encounters; establishing a meaningful connection with the patient; skillfully performing nursing activities; rationally determining an appropriate course of nursing action; and morally conducting one's nursing practice. There are parallels between Johnson's philosophical investigation and the realities of the art and science of nursing today. Patient and relationship-centered practice closely relates to establishing a meaningful connection; while skillfully performing and rationally determining nursing activities relates to the use of an empirical knowledge base (Finfgeld-Connett, 2008).

Caring in Nursing. At the essence and core of nursing is human care. As medical technology has advanced the emphasis on caring relationships and human care has diminished. Nursing has both a social and moral responsibility to human care ideals and practice. Watson (1985) claims the moral ideal of nursing is the "protection, enhancement, and preservation of human dignity" (p. 29). Whereby, Swanson (1991) sees the caring ideal as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 165). Both Watson and Swanson idealize caring in nursing as focusing on the value of the relationship with each individual person through a commitment to receptiveness and responsiveness to the patient's needs. Swanson's (1991) theory of caring describes five caring categories or processes including knowing, being with, doing for, enabling, and maintaining belief. Integral to knowing is "striving to understand an event as it has meaning in the life of the other" (Swanson, 1991, p. 162). The caregiver "centers on the one cared for" (p. 162) and strives to understand the personal reality and meaning of events and experiences of the one cared for (Swanson, 1991). The value of knowing the patient from the patient's perspective is emerging as a central feature of patient-centered care and a vital aspect of a caring relationship.

The Social Context of Nursing. The social contract between society and the profession of nursing is described in the American Nurses Association's *Nursing's Social Policy Statement* (2003). The statement describes nursing in relation to society as the "pivotal health care profession, highly valued for its specialized knowledge, skill and caring in improving the health status of the public and ensuring safe, effective, quality care" (p. 1). This social contract outlines values and assumptions, two of which directly

relate to the relationship between the nurse and the patient. They include, "the relationship between nurse and patient involves participation of both in the process of care," and "the interaction between nurse and patient occurs within the context of the values and beliefs of the patient and the nurse" (American Nurses Association, 2003, p. 3). Without knowing the patient and developing a relationship with the patient, the nurse will be unable to interact within the values and beliefs of individual patients and their families. Instead, nurses will rely upon their own values, beliefs, and assumptions when interacting with patients and families. Working and practicing under the context of *Nurse's Social Policy Statement* is an obligation the nursing profession has to society as a whole (American Nurses Association, 2003).

Knowing in Nursing

Fundamental patterns of knowing. Nursing is an interpersonal, relationship-building process closely involving the patient in every interaction and aspect of care. Nursing practice involves many patterns of knowing in order to a meet patient needs from a holism perspective. Carper (1978) identified four fundamental patterns of knowing which are separated according to logical type of meaning. These patterns include empirics, esthetics, personal knowledge, and ethics (Carper, 1978). Personal knowledge is gained through "empathetic acquaintances" with patients and is the most difficult to master (Carper, 1978). Increasing abilities to empathize with patients enables the nurse to more effectively develop authentic personal relationships and add integrity to the personal encounter (Carper, 1978). By incorporating a unique understanding of patients' lives, nurses can individualize their approach to patients and gain insight into health and wellness beliefs.

Primary to all knowing, empiric, esthetic, ethical, and others, is personal knowing (Smith, 1992). Personal knowing relates to one's own self as well as to other selves. Through self-awareness and self-reflection, nurses can come to know their authentic self which enables them to uniquely present themselves within the therapeutic relationship with the patient. Without this personal knowing of oneself, which enables openness for knowing of another, nursing is only technical assistance, not compassionate, patient-centered care (White, 1995). This subjective type of personal knowing is shaped through personal experience and engagement with the environment and is affected by how individuals perceive these experiences (Bonis, 2009). Therefore, human experiences are embraced through this ontological shift to a subjective type of knowing.

Knowing the patient. An important aspect of nursing is knowing the patient. According to Polanyi (1958), knowing is holistic and personal and aims at finding reality through the process of aesthetics, science, and ethics. Knowing the patient is a necessary precursor for effective nurse-patient interactions and contributes to the nurse's ability to successfully make decisions regarding clinical treatments (Finch, 2004; Mantzorou & Mastrogiannis, 2011). Through repeated experiences with patients, patient knowing develops and care can become individualized as opposed to standardized (Evans, 1996). This understanding of patient's unique response to clinical treatment evolves through an interrelationship between an accurate understanding of the patient and effective nurse-patient communication (Bonis, 2009; Finch, 2004).

Since Carper's landmark work in 1978, the concept of knowing has been analyzed, defined, and identified within different contexts of nursing. Following the guidelines of naturalistic inquiry, Jenks (1993) used focus groups and observations to

investigate practicing nurses' perceptions of clinical decision making. Participants included 23 professional nurses working on 10 different units within a hospital setting. Analysis of focus group transcripts and field notes yielded four major themes. One of the four themes included 'knowing' which was defined as "having personal knowledge about another individual through an interpersonal relationship" (Jenks, 1993, p. 401). Knowing was described as more than knowing about patients, it also included the establishment of personal relationships with patients. This personal relationship was needed to facilitate effective clinical decision making and reduce the occurrence of difficult and erroneous decisions (Jenks, 1993). Similarly, a grounded theory research method was used by Henderson (1997) to describe from the nurses' and patients' perspective, factors which inhibit or facilitate the process of nurses knowing the patient. While knowing the patient on a personal level as well as a professional basis increases the degree of patient participation, there are factors which both enhance and inhibit this process (Henderson, 1997). Enhancing factors include mutual rapport and trust, positive nurse-patient attitude, sustained nurse-patient contact, and meaningful interaction (Henderson, 1997). When nurses knew patients as people rather than as bodies in a bed, patients perceived increased comfort communicating their needs regarding their care which facilitated mutual trust, rapport, and participation wholly in their care (Henderson, 1997).

Knowing and patient-centered care. Knowing the patient involves two broad dimensions; knowing the patient as a person and knowing the patient's pattern of responses (Mantzorou & Mastrogiannis, 2011). Since each patient has a unique history, patient-centered nursing requires the nurse to learn about their patient's experiences, behaviors, feelings and perceptions (Radwin, 1995). Individualized interventions,

reflective of patients' experiences, behaviors, feelings, and perceptions, can then be determined and implemented. In an ethnography study, Crocker and Scholes (2009) observed mechanical ventilation weaning by nurses over a six month period. Data collected from focused interviews, field notes, and participant observations were analyzed using a content analysis approach. Four themes emerged with 'knowing the patient' identified as a central theme and an essential element of patient-centered, individualized care (Crocker & Scholes, 2009). Since this study was limited to the intensive care unit (ICU) and patients being weaned from a ventilator, generalization to other patient populations is difficult. However, the value of knowing the patient, even under the difficult circumstances of ICU care and ventilator weaning, is clear. To be truly patient-centered, nurses must know their patient and provide care from this context.

Knowing and expert practice. The publication of *The Future of Nursing: Leading Changing Advancing Health* (IOM, 2011a) has put focus on professional nursing practice and the need for expert nurses to drive the vision laid out in the report. With the elusive nature of expert nursing characteristics and behavioral expectations, clarification of this important concept is needed. An integrative review on expert practice in nursing by Morrison and Symes (2011) evaluated common characteristics of expert practice in nursing across several nursing specialties and work settings. A descriptive synthesis of 16 studies, 11 qualitative and five non-experimental quantitative, revealed five themes characterizing expert practice. The five themes included knowing the patient, intuitive knowledge and pattern recognition, risk taking, reflective practice, and skilled know-how (Morrison & Symes, 2011). Also contributing to expert practice were work environmental factors including nursing leadership, positive nurse-physician relationship,

autonomy, nurse-patient relations, recognition, and role model mentors (Morrison & Symes, 2011). Expert nursing care requires a patient-centered focus with includes truly knowing the patient.

Knowing and patient safety. Historically, nurses have intuitively known how important knowing their patients and developing a therapeutic relationship with patients is to the overall process of good care. In the past decade the concept of patient safety has become part of the fabric of healthcare. Getting to know the patient is a critical step in the process of providing safe care. In the current healthcare environment where managing the technical aspects of sicker and sicker patients requires more nursing time, taking the extra time to get to know the patient may not seem like a priority. However, taking the time to converse with a patient and develop a relationship of trust is a safety intervention potentially providing critical information which may prevent a medical error (Beyea, 2006). Using focus groups of intensive care nurses in an exploratory study, Henneman et al. (2010), identified strategies to identify, interrupt, and correct errors. Based on the description of strategies used to identify errors, eight themes were revealed. Knowing the patient through establishing a relationship with the patient and the family was a reoccurring theme important for identifying errors and ensuring patient safety (Henneman et al., 2010).

Barriers to knowing. The healthcare profession has a responsibility to address barriers which limit a caregiver's ability to develop therapeutic relationships with patients, relationships which lead to patient's feeling known by their nurse or caregiver. These barriers can stem from both the nurse as well as from the patient perspective. A perceived barrier preventing nurses from getting to know their patients and encouraging

their patients to participate in their care is the extra nursing time required to conduct these activities. In today's highly technical environment with emphasis on task-oriented activities and getting the work done, the perception of lack of time and resources is voiced by healthcare providers as a factor preventing the establishment of patient-centered relationships and care (Crocker & Scholas, 2009). In addition, long standing, deeply embedded traditional patient and caregiver roles within the healthcare culture are contributing to poorly established relationships and knowing the patient (Longtin et al., 2010). In order to create patient-centered relationships, nurses need to be willing to give up control and delegate power to the patient in regards to their care and healthcare decisions (Longtin et al., 2010). Patients, on the other hand, need to accept the responsibility to participate in their own care and decision-making.

Consequences of knowing. Consequences surrounding knowing the patient present as both a positive and a negative effect. In a concept analysis on knowing, the consequences of understanding, finding meaning, and transformation were determined (Bonis, 2009). When nurses know their patients, they understand the uniqueness of the individual and are able to plan appropriate therapeutic interventions. Through the process of coming to know the patient, nurses guide patients to finding meaning in their experiences which contributes to understanding their health experiences. In the ongoing process of knowing, understanding, and finding meaning, the consequence of transformation evolves. In the end, knowing the patient transforms the relationship between the nurse and the patient, thereby promoting insightful, patient-centered care (Bonis, 2009).

Not knowing the patient potentially has consequences which directly affect the patient negatively. When nurses and healthcare providers fail to know the patient and their unique situation, a standardized approach to care which depersonalizes patients occurs. This standardized approach denies patients their dignity and enhances their feelings of insecurity and vulnerability (Whittemore, 2000). In addition, not knowing patients unique self creates difficulty in fulfilling the patient advocacy role (Tanner, Benner, Chesla, & Gordon, 1993). Fulfillment of this role requires thorough knowledge of a patient's clinical and psychological status, as well as their ethical values and beliefs. Advocating for patients during times of vulnerability and weakness is an important nursing value which can only happen through knowing the patient (Tanner et al., 1993). Overall, lack of being known has consequences for the delivery of safe patient care, and patients are potentially deprived of a caring and therapeutic relationship.

Patients' perception of feeling known by their nurse. The importance and high level priority nursing places on knowing the patient has been well established; however, limited research has been conducted exploring the patients' perception of feeling known by their nurse. Somerville (2009a) began the work to develop and psychometrically test a reliable and valid measure of patients' perceptions of feeling known by their nurses. The development of the P*atients' Perceptions of Feeling Known by their Nurses Scale* (PPFKN) was guided by the theoretical framework of Health as Expanding Consciousness (Newman, 1994) and focuses on "the patient experience, as well as the experience of being recognized as a unique human being, who feels safe and experiences a meaningful, personal connection to their nurse that facilitates and empowers the patient to participate in their care" (Somerville, 2009a, p. 2). The scale incorporates four themes

which describe the patients' perceptions of feeling known by their nurses: 1) experienced being recognized by their nurses as a unique human being, 2) felt safe, 3) experienced a meaningful, personal connection with their nurses, and 4) felt empowered by their nurses to participate in their care (Somerville, 2009a). Each of these four themes is an integral part of a patient-centered model of care, where the development of a therapeutic relationship and knowing the patient are key, critical elements in the care delivery process.

Recognized as a unique human being. Recognizing patients as unique human beings is central to patient-centered care. The uniqueness of each person is revealed through the provision of care which respects patients' individual values and preferences. Through knowing the patient, the nurse acquires insight into the history and experiences of the patient, creating opportunity to accept the patient as unique (Somerville, 2009a). When a nurse understands patients' unique patterns, therapeutic plans of care can be developed in addition to recognition of alterations in these patterns (Bonis, 2009). Through the process of knowing the patient and recognizing that person as unique human being, nurses can individualize patient care by choosing interventions specific not only to their needs, but their values and beliefs (Radwin, 1996).

The individualization of patient care is highly valued by patients and their families, and is correlated with high levels of patient satisfaction and quality of life (Radwin & Alster, 2002; Suhonen, Välimäki, Katajisto, & Leino-Kilpi, 2007). To improve the understanding of individualized care from the patients' perspective, a study using the Individualized Care Scale (ICS) was conducted with orthopaedic and trauma patients (Land & Suhonen, 2009). A majority (63%) of the patients strongly agreed

being treated as a unique individual was very important, however only 55% actually experience this type of care (Land & Suhonen, 2009). In addition, patients agreed strongly that individuality was supported through specific nursing interventions, as well as encouraging them to take responsibility for their own care (Land & Suhonen, 2009). Improving the provision of individualized care is central to a patient-centered model of care and for recognizing patients as unique human beings. Understanding how patients perceive the care provided them is important to nursing practice; while knowing the patient and treating them uniquely is a strongly held nursing value (Radwin, 1996).

Feeling safe. It has been found that feeling safe is an overarching need for patients during inpatient hospital stays (Aro, Pietilä, & Vehviläinen-Julkunen, 2012; Hupcey, 2000; Lasiter, 2011). To patients, to feel safe may be much different than being safe. However, as people work at all levels of health care to improve the safety and quality of care, is it really known what it means to the patient to feel safe? Using the questionnaire *Needs of Adult Patients in Intensive Care Unit,* Aro et al. (2012) measured the perceived needs of 166 patients in six different ICUs. As supported by previous studies (Hofhuis et al., 2008; Hupcey, 2000), this study indicated the need for feeling safe, physical comfort, respect as a unique individual, being informed and providing emotional support as very important to patients in an ICU. Overall, the most important needs expressed by patients were the dimensions of feeling safe at 97.2% and physical comfort at 98.4% (Aro et al., 2012). Through a grounded theory approach, Hupcey (2000) measured the psychosocial needs of 45 patients in the medical and surgical ICU of a large rural, tertiary medical care center. A model was developed around the core variable *feeling safe*, with four categories, knowing, regaining control, trusting, and

hoping, affecting the patient's experience of feeling safe. Specifically, when a patient feels a loss of control or loses trust in staff, they feel unsafe. However, when patients' psychosocial needs are met, patients will express feelings of safety (Hupcey, 2000). Other factors influencing feeling safe were the contribution of family, friends, staff, and religion in meeting patient needs.

With the population aging, studies specifically exploring older adults' experiences and perceptions of care during hospitalization are becoming increasingly important. Lasiter (2011) explored perceptions of feeling safe in older adults after a critical illness requiring intensive care. Using a ground theory approach, ten older adults discussed their experiences of feeling safe during their recent intensive care stay. Through the data, four main categories were identified: initiative, having a way to initiate nurse-patient interaction; proximity, able to see or hear the nurse; oversight, checking and monitoring by the nurse; and predictability, perceiving nurse as qualified with consistent behaviors. All participants incorporated two or more categories in their discussion, which implies the need for at least two of the four categories to exist in order for patients to feel safe. Although monitoring and checking are important aspects of feeling safe, patients require accessibility, proximity, and interaction within the nurse-patient relationship (Lasiter, 2011). Using semi-structured interviews, Andersson, Burman, and Skär (2011) described the experiences of care during hospitalization from the perspective of people aged 65 or older. Patients expressed the importance of developing a feeling of safety while hospitalized. Staff actions which led to feeling safe included getting timely assistance, frequent checking and the development of a good relationship between the patient and the staff (Andersson et al., 2011).

Nursing has a professional and ethical responsibility to develop therapeutic, caring relationships with each patient (Karlsson & Forsberg, 2008; Lasiter, 2011; Lindwall, von Post, & Bergbom, 2003). These relationships are essential to positive patient outcomes and satisfaction with care. Therapeutic and caring relationships are established through interaction with patients, whereby nurses demonstrate caring by spending time with patients and individualizing each aspect of care provided (Andersson et al., 2011; Karlsson & Forsberg, 2008). Once a therapeutic relationship has been established, patients begin to develop trust in the nurse which leads to the experience of feeling safe (Lasiter, 2011; Nieminen, Mannevaara, & Fagerström, 2011).

Recent research by Lasiter and Duffy (2013) is focused on the development of a theory around safety from the patient's perspective as opposed to emphasis on providers. Using a grounded theory approach, Lasiter and Duffy (2013) considered older adults' perceptions of feeling safe in two hospital acute care units. This work began the development of a feeling safe theory, identifying the factors of oversight, predictable, personalized, and advocate, as contributors to the patients' perception of feeling safe in acute care (Lasiter & Duffy 2013). Through the facilitation of practice environments which support nurses in balancing workflow with patient-centered care delivery models, nurse leaders can contribute to patient experiences of feeling safe during healthcare encounters.

Connection. In order for patients to perceive their nurse as caring and present, the patient must experience a meaningful and personal connection during their time together. Connectedness or personal connection can be defined as a perceived shared and meaningful relationship with another person, or a mutual and shared partnership between

the nurse and the patient (Phillips-Salimi, Hasse, & Kooken, 2012; Somerville, 2009a). As the connection between the nurse and the patient deepens, a relationship grounded in trust and respect develops, allowing for a mutual sharing of experiences and knowledge (Appleton, 1993). Exploring a patient's experience and meaning of patient-centered care through a phenomenological study, Marshall, Kitson, and Zeitz (2012) identified three staff related subthemes of connectedness, involvement, and attentiveness. Connectedness between the nurse and the patient emerged strongly, and was related to the person to person interactions, relationships, and respect, which developed during the course of care provided (Marshall et al., 2012). Patients expressed respect as an important aspect of connectedness with value placed on connecting at a personal level and being treated as a person, not just a patient. In addition, being involved was identified as a key aspect of connectedness. Being involved was described as information sharing, equality and a process of consultation between the nurse and the patient (Marshall et al., 2012).

Participate in care. The level and readiness for participation in care will vary from patient to patient depending on their clinical status, their cognitive abilities, and the value placed on involvement. Patient participation in care is related to knowing the patient and consequently, by knowing the patient, nurses are able to individually provide care designed to meet patient preferences (Radwin, 1996). Patients may be willing to participate in their care, however fully understanding how patients define participation in care is necessary to allow the nurse the opportunity to individualize their approach to the patient. Distinctive attributes defining and conceptualizing patient participation include establishing a trusted, mutually respective, and connected relationship; sharing of information and knowledge; mutual engagement; and surrendering of power and control

(Sahlsten, Larsson, Sjöström, & Plos, 2008). Seeking information around the patients' preferred level of involvement in their care is a critical aspect of relationship building between the nurse and the patient. Additionally, once the level of participation is determined, healthcare providers must embrace the patient's definition of participation (Eldh, Ekman, & Ehnfors, 2010). The most effective process for determining the level of participation desired by the patient is to ask the patient. To elicit a patient's definition of participation, Eldh, Ekman, and Ehnfors (2010) used a closed-ended and open-ended questionnaire to solicit information from 362 patients with a recent patient experience. Major themes revealed patients primarily describe participation as involving respect, especially around being listened to, and being regarded as an individual when receiving information on their specific situation (Eldh et al., 2010). Patients require knowledge to participate in their care, and this study supports the provision of knowledge to the patient as a central and essential attribute of patient participation (Eldh et al., 2010). When patients participate in their care, their commitment to the recovery process may increase as well as their feelings of security within the healthcare environment (Höglund, Winblad, Arnetz, & Arnetz, 2010). However, a barrier to patients participating in their care is whether they prefer to participate.

Sometimes, despite positive efforts towards knowing the patient and developing a therapeutic relationship, patients present barriers in the process. With historical roles in healthcare centering more from a "paternalist model," patients have traditionally been passive spectators in their own care and treatment (Longtin et al., 2010). When healthcare providers are encouraging patients to participate in their care and decision-making, consideration to the patient's level of knowledge, level of health literacy, and

acceptance of this new role will be important. In addition, demographic characteristics of the patient, such as age, sex, and ethnic origin, may present additional barriers. Using a cross-sectional design, 428 patients recently discharged from inpatient care were surveyed using the Control Preference Scale (CPS) to investigate predictors of preference for participation in decision-making (Florin, Ehrenberg, & Ehnfors, 2008). The CPS has five preference levels for participating in decision-making which are defined by three roles: passive, collaborative, and active. Patients rank their preferred role in the decision-making process from most preferred to least preferred. Adopting a passive role, *nurse to make final decisions about treatments*, was the most preferred role (51%), however 29% of those choosing a passive role wanted the nurse to hear their opinion and use this knowledge in the decision-making process (Florin et al., 2008). Encouraging patients to participate in their care provides avenues for the individualization of their care and increases their knowledge for making informed choices regarding their healthcare, in addition to increasing personal autonomy and an overall sense of wellbeing.

Additionally, barriers to patients taking an active role in their own nursing care was explored through focus groups consisting of inpatients from four hospitals using patients aged 32-87 years (Larsson, Sahlsten, Segesten, & Plos, 2011). Through these focus groups, four categories, each with underlying subcategories, were found to inhibit patient's participation in nursing care. One category, facing own inability, included insufficient knowledge around health situation. A second category, receiving a lack of empathy, reflected the nurse's inability to connect emotionally with the patient and unfamiliarity with the patient's individual situation. Encountering a paternalistic attitude was a category where the exertion of control and power dominates the relationship

between patient and nurse. The final category, sensing structural barriers, depicts issues around the lack of individualized care and poor communication between caregivers (Larsson et al., 2011). Findings from this study demonstrate patients do not necessarily see themselves as partners in nursing care, and patients continue to choose whether to take an active or passive role in their healthcare. In addition, the findings highlight power imbalances which continue to exist between nurses and patients, bringing awareness to the importance of minimizing these imbalances (Larsson et al., 2011). Striving to provide opportunities to encourage patients to fully participate in their care and individualizing each patient's nursing care are necessary prerequisites to overcoming barriers around patient participation in nursing care and fully achieving the patient's participation in their care.

Practice Environment

There has been an increased focus on the environment where patient care is provided. Improved practice environments are critical for quality patient care, patient and nurse satisfaction, and staff retention. In today's regulatory-driven healthcare environment, the ability to meet financial and quality strategic goals is imperative to survive in today's highly competitive healthcare market. With nursing comprising the largest segment of the healthcare workforce, focusing on nurse perceptions of their practice environment is becoming a higher priority. With multiple valid and reliable instruments to measure the practice environment available, nursing and healthcare leaders may have difficulty deciding which to choose. The *Revised Nursing Work Index* has been one of the most widely used instruments; however the data can be analyzed in different ways (Cho, Mark, Yun, & June, 2011; Lake, 2007). Practice environment data

can be aggregated to the hospital or unit level, with variable results potentially obtained. Cho et al. (2011) found there was not always congruence between composite and subscale scores, suggesting practice environment variability across nursing units be considered if conducting hospital level analyses. With the complex and multi-faceted nature of the practice environment and the individuality required for specific patient populations and levels of care, practice environment measurement has been difficult and challenging.

If we are to develop and improve patient-centered models of care, we must first create environments where nurses are empowered to have an active and dominant role in both unit and organizational level decision-making. Dimensions of an optimal healthcare practice environment have been proposed to include climates for patient-centered care and quality improvement, in addition to a benevolent ethical climate (Rathert & May, 2007). Exploring how these practice environment dimensions relate to staff and patient outcomes, Rathert, Ishqaidef, and May (2009) used the variables of organizational commitment, patient safety, and job engagement to empirically test for a relationship with the practice environment. Considering the patient-centered care aspect of an environment, Rathert et al. (2009) hypothesized there is a positive relationship to the job engagement, organizational commitment, and psychological safety of care providers. Using regression modeling, analysis demonstrated patient-centered care had a) a significant, positive relationship with organizational commitment (β=0.45, z=2.7) and b) a significant, negative relationship with engagement (β= -0.61, *z*= -2.74), and psychological safety (β= -.67, *z*= -1.93) (Rathert et al., 2009). Overall, this study provides evidence regarding the practice environment as an important predictor of staff

commitment and engagement, in addition to supporting the importance of establishing patient centered models of care.

Practice environment and leadership. Nursing leaders are in a unique position to influence the practice environment, either positively or negatively, thereby impacting staff and patient outcomes. Leaders who create practice environments conducive to the enactment of caring demonstrate the value of caring over simple task completion (Finfgeld-Connett, 2008). Studies have associated positive staff and patient outcomes to practice environments which support staff empowerment, patient centered care, shared governance, and a commitment to continuous quality improvement (Armellino, Griffin, & Fitzpatrick, 2010; Armstrong, Laschinger, & Wong, 2009; Clavelle, Porter O'Grady, & Drenkard, 2013; Donahue, Piazza, Griffin, Patricia, & Fitzpatrick, 2008; Rathert et al., 2009; Rathert & May, 2007; Squires, Tourangeau, Laschinger, & Doran, 2010; Thompson et al., 2011).

The strength of the relationship between leader and staff effects staff satisfaction which leads to improved staff retention and overall job engagement (Bamford, Wong, & Laschinger, 2013; Duffield, Roche, Blay, & Stasa, 2010; Thompson et al., 2011). In a cross-sectional survey of staff and unit directors in an academic medical center, a leader-member exchange (LMX) perspective was used to assess staff perceptions of safety climate and leadership characteristics. An LMX is grounded in social exchange theory and hypothesizes that leaders who develop relationships with staff based on trust, respect, and obligation are more successful than leaders who do not (Thompson et al., 2011). The *Leader-Membership Exchange Tool* (LMX-7) was used to measure staff's perceptions of differentiated relationships. In units with high relational leaders, the staff had a positive

perception of the practice environment (Thompson et al., 2011). Additionally, Duffield et al. (2010) used the *Nursing Work Index-revised* (NWI-R) to examine nursing unit manager's leadership characteristics on staff satisfaction and retention in 94 patient care units in 21 hospitals. The NWI-R has five domains (autonomy, leadership, resource adequacy, control over practice, and nurse/physician relations) and this study focused on the leadership domain which contains 12 items. Results suggested high performing and positively rated units had Nurse Managers performing well on all 12 aspects measured in the leadership domain (Duffield et al., 2010). Effective nurse managers who have expansive, all-encompassing leadership skills are instrumental in nurses' satisfaction not only in their current role but in the nursing profession overall.

An aspect of the practice environment which has been tied closely with positive nurse satisfaction is empowerment, both structural and psychological. Empowerment in the workplace is a leadership strategy known to create a positive practice environment and organizational commitment. Empowerment has been linked to increased nurse retention and high quality professional nursing care (Laschinger, Finegan, & Wilk, 2009). It is critical to establish a perception of empowerment within nurses' practice environments in order to improve patient safety, outcomes, and organizational success. A study by Armellino et al. (2010) considered the relationship between structural empowerment and a culture of patient safety within a critical care environment. Using the *Conditions of Workplace Effectiveness* (CWEQ-II) and the *Hospital Survey on Patient Safety Culture* (HSOPSC), a significant correlation ($r = 0.32$, $p < 0.05$) was found between structural empowerment and the perception of patient safety culture (Armellino et al., 2010). The CWEQ-II is based on Kanter's (1993) theory of organizational behavior

and measures perceived empowerment of respondents when they are given access to information, resources, support, and opportunity. The 19-item questionnaire uses a 5-point scale and consists of six subscales. Higher scores correlate to higher levels of empowerment (Armellino et al., 2010). In addition, staff perception of available opportunities for involvement decreased as the age and number of years worked increased. Creating opportunities to encourage experienced nurses to become involved in unit and hospital level activities to improve the practice environment may improve perceptions of structural empowerment, the safety culture within the environment, job satisfaction, and overall quality of care.

A method widely utilized in Magnet® organizations to improve the empowerment and engagement in nurse practice environments, is shared governance. Shared governance is a decision-making process shared by leadership and staff, thereby giving greater autonomy and control over practice to the nurses which creates a sense of accountability and responsibility (O'May & Buchan, 1999). Clavell et al. (2013), used the *Index of Professional Governance* (IPNG) and the NWI-R to describe the relationship between the nurse practice environment and shared governance. A highly significantly, positive relationship (r= 0.416, P<.001) was found between the total scores of the IPNG and the NWI-R (Clavelle et al.,2013). Additionally, a moderately strong significant relationship was found between the IPNG subscale of control over personnel and the NWI-R subscale of organizational support (r= 0.42, P<.001), the NWI-R subscale of autonomy and the IPNG subscale of control over practice (r= 0.38, P<.001), the IPNG subscale of control over practice and NWI-R subscale of autonomy (r= 0.367, P<.001), and the NWI-R subscale of autonomy and resources supporting practice (r= 0.365,

P<.001) (Clavelle et al., 2013). Overall, this study demonstrated the positive relationship between the nurse practice environment and shared governance leadership models, with nursing autonomy the most significantly correlated characteristic.

Exploring the relationship between empowerment, practice environment characteristics, and patient safety climate provides important information to create environments supportive of professional practice. Nurses who perceive their level of empowerment as high tend to have higher organizational commitment, greater levels of autonomy, and increased job satisfaction, which influence patient outcomes positively. Significant positive relationships have been demonstrated between perceptions of empowerment and access to resources, support, opportunities, and information as well as with patient satisfaction scores (r = .169; p <.05) in nursing care unit with high empowerment levels (Donahue et al., 2008). In a study examining the relationship between empowerment, environment characteristics and patient safety climate, Armstrong et al. (2009) found overall empowerment strongly related to leadership ability (r = 0.66; p = .0001) and nurses participating in organizational affairs (r = 0.64; p = .0001). This study used the CWEQ-II to measure perceived levels of empowerment, the *Practice Environment Scale of the Nursing Work Index* (PES-NWI) to measure hospital characteristics and the *Safety Climate Survey* to measure the patient safety climate. As hypothesized, overall empowerment was positively related to hospital characteristics (r = 0.72; p = .0001) and perceptions of patient safety climate (r = 0.60; p = .0001) (Armstrong et al., 2009). An important link between the level of patient safety climate and quality of the nurses work environment was demonstrated. The influence of the nurse leader in creating practice environments which empower nurses to practice patient-

centered, high quality care, while providing adequate assistance and resources in which to support care is highly valued by nurses and represents effective and authentic leadership.

Practice environment and patient satisfaction. In 2001, the IOM published *Crossing the quality chasm: A new health care system for the 21st century,* where six high priority aims were recommended. One of the six aims focused on patient-centered care specifically recommending "putting the patient in the driver's seat; offering choices; respecting diversity; and involving loved ones" (IOM, 2001, p. 12). Patients are the source of control when it comes to their care and need to share in the decision-making regarding their care. This shared decision-making can only happen through improved approaches to listening and the customization of patient care by health care providers (IOM, 2001).

In today's healthcare environment, staff and patient satisfaction are important aspects of organizational success. Patients' perception of their care and involvement in their care can be closely linked to their satisfaction. Hospitalized patients spend a great deal of time in the presence of a nurse. Overall satisfaction of patients can be influenced by time spent receiving direct care from nursing staff and other members of the interdisciplinary team. Development of therapeutic relationships with patients and their families is a critical element to their satisfaction (Boev, 2012).

Historically, healthcare providers have measured the satisfaction of patients through multiple means, from self-created surveys to nationally benchmarked surveys such as Press Ganey®. With the passing of the Patient Protection and Affordable Care Act of 2010 (ACA), healthcare providers receiving reimbursement from Centers for Medicare and Medicaid (CMS) are required to collect patient satisfaction data for

calculation under the Value-Based Purchasing program (VBP). The instrument used to collect patient satisfaction data is the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (CMS, 2011). The HCAHPS survey is an instrument for collecting data regarding the hospital experience from the patient's perception. The HCAHPS survey provides a national standard for comparisons about the patient experience of care during an inpatient hospitalization (CMS, 2013). The results from HCAHPS surveys are an aspect of the Patient Experience of Care domain under the VBP program which determines a portion of hospital reimbursement. In addition, results from the HCAHPS surveys are publically reported on the "Hospital Compare" website which is available for consumers to compare the performance of different hospitals (CMS, 2013).

One of the primary measures of success on the HCAHPS survey is "willingness to recommend" the hospital to friends and family. Willingness to recommend may be a better predictor of the consumer's intention to return to the health care provider than overall satisfaction (Klinkenberg et al., 2011). Using HCAHPS survey, data collected over a one year period of time (July 2007 through June 2008) from 131 hospitals, and 33,445 patients, found a high level of satisfaction, 77.2% responding "definitely yes," with willingness to recommend (Klinkenberg et al., 2011). The strongest predictor of willingness to recommend was related to perceptions of nursing care across all care unit types (Klinkenberg et al., 2011). Implications from this research point to the importance of the interpersonal aspects of care and how caregivers, who respond compassionately attending to the emotional state of patients, tend to be remembered favorably after care is provided thus driving up satisfaction (Klinkenberg et al., 2011). When patients are very

satisfied with their care from the nurse they are more likely to recommend the hospital and be satisfied with their overall care.

Patient satisfaction is an important part of the VBP incentive in which all hospitals reimbursed by Medicare must participate. Hospitals now have an incentive to improve their quality of care and the satisfaction of patients. With nurses spending the highest percentage of time with the patient during inpatient hospital stays, hospital administrators and leaders have motivation for examining the relationship between the practice environment and satisfaction of patients.

Practice environment, patient outcomes, and quality of care. A link between improved patient outcomes and superior care environments has been consistently demonstrated in the literature, especially in Magnet® designated hospitals (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Klaus, Ekerdt, & Gajewski, 2012; Lake & Friese, 2006). Using the National Database of Nursing Quality Indicators® (NDNQI) *RN survey with Job Satisfaction Scales*©, Klaus et al. (2012) investigated which unit, hospital, and individual characteristics in four age groups, age 20-59, predict job satisfaction in a sample of 53,851 RNs. Some characteristics differed by age groups, but a significant finding across all age groups was the unit based quality care in relation to job satisfaction. The higher the perceptions of unit quality of care the higher nurse job satisfaction (Klaus et al., 2012). Using the PES-NWI to evaluate the nurse care environment, Aiken et al. (2008), studied 168 acute care hospitals in Pennsylvania. Evaluating outcomes from 232,342 patients aged 20 to 85; the likelihood of dying was 14% lower in a ‘better’ care environment hospital than a ‘poor’ care environment hospital (Aiken et al., 2008).

Improving the care environment was demonstrated in this study to contribute to better patient outcomes (Aiken et al., 2008).

The nurse practice environment, in addition to the culture of the organization, plays a critical role in influencing the quality and safety of care provided. Researching whether a relationship exists between levels and specialties of care and patient outcomes, such as quality of care and adverse patient events, is important for understanding the subcultures of an organization. Using the NWI- R and *Maslach Burnout Inventory* (MBI), Mallidou, Cummings, Estabrooks, and Giovannetti (2011) explored the effect of four nurse specialty subcultures (medical, surgical, critical care and emergency care) on quality of care, adverse patient events and job satisfaction. Control over practice as measured by the NWI-R increased job satisfaction in the critical care and surgical specialties, in addition to having the significantly strongest association with quality of care (Mallidou et al., 2011). Furthermore, practice environments associated with low decision latitude, high workload, and poor patient outcomes are likely to have low job satisfaction and be considered unfavorable environments. A cross-sectional study, using 116 nursing units in eight hospitals, investigated the impact of nurse work characteristics, the nurse practice environment and burnout on unit level, nurse reported quality of care, job outcomes, and patient safety (Van Bogaert et al., 2014). Three dimensions of the NWI-R, nurse-physician relations, unit level nursing management, and organizational support and hospital management, and three instruments measuring the nurse work characteristics of decision latitude, social capital, and perceived workload were used to assess the unit level effects via multilevel modelling. Nosocomial infections and medication errors were significantly associated with nurse-physician relations and

management at both the unit and hospital level (Van Bogaert et al., 2014). Additionally, patient falls, nosocomial infections, and medication errors were significantly associated with emotional exhaustion and depersonalization (Van Bogaert et al., 2014). The results of this study emphasiziesthe relationship between feelings of exhaustion and burnout and how working in unfavorable practice environments can affect quality of care and patient outcomes.

In an effort to improve the practice environment and quality of care, Eaton-Spiva et al. (2010) used focus group sessions and surveys in four nursing units to assess the practice environment, barriers to quality care, perceived nurse empowerment, and the unit's overall culture. Findings from this mixed methods study identified nurse-physician relationships, and staffing and resource adequacy as barriers to quality care, which contributed to low perceptions of the practice environment (Eaton-Spiva et al., 2010). In addition, nurses expressed a desire to understand the patient's feelings, but were unable to do this due to lack of time (Eaton-Spiva et al., 2010). Additionally, the effect of the practice environment on quality of care outcomes across multiple countries was explored using the PES-NWI (Aiken, Sloane, et al., 2011). Obtaining data from nearly 100,000 bedside nurses in 1406 hospitals in nine countries, variability in the quality of the practice environment was found across all nine countries (Aiken, Sloane, et al., 2011). Hospitals with better practice environments, as opposed to poor or mixed environments, were significantly associated with lower odds of nurse burnout (OR = .54 -.72) and job dissatisfaction (OR = .33 - .68), in addition to better quality of care outcomes (OR = .25 - .67) (Aiken, Sloane, et al., 2011). The overall culture of the practice environment, along with adequate resources, are critical factors contributing to the nurse's ability to

focus on knowing the patient, developing a therapeutic relationship, and providing quality, patient-focused care.

Practice environment and patient safety. The practice environment where care is delivered can be closely linked to patient safety, contributing to the potential for errors and overall safety, both real and perceived, within an operational unit or larger organizational entity (Squire et al., 2010). The culture of the organization, the effectiveness of leadership, adequacy of staffing, and the work design within the environment all represent potential threats to patient safety and outcomes (IOM, 2001). In order to create practice environments designed to drive safer more compassionate patient-centered care, nurse leaders must not only be innovative, but possess strong leadership skills and traits.

The role of frontline leader involves multiple leadership skills and traits which are necessary to promote patient safety, staff satisfaction, and positive practice environments. In a study of 600 acute care nurses, Squires et al. (2010) hypothesized that resonant leadership styles and perceptions of interactional justice would enhance the relationship between the nurse leader and nurses, thus influencing patient outcomes. Through the use of six valid and reliable instruments, the constructs of resonant leadership, interactional justice, span of control, safety climate, and practice environment were measured. Results of this study indicated the importance of the nurse leaders' relationship with staff and in fostering quality practice environments which promote a positive safety climate (Squires et al., 2010). Additionally, Kirwan, Matthews, and Scott (2013) used nurse-reported patient safety and adverse event reporting to explore the link between the practice environment and patient safety outcomes. Using the PES-NWI to measure the practice

environment in 108 medical and surgical units in 30 hospitals, this study found a significant relationship (F=41.671, p<.001) between the practice environment and adverse event reporting (Kirwan et al., 2013). Findings from this study not only provide empirical evidence linking positive practice environments with higher nurse reported patient safety, the results are consistent with previous research results where associations between the practice environment and patient safety outcomes were demonstrated (Aiken, Cimiotti, et al., 2011; Kirwan et al., 2013). Overall, hospitals and nursing units with better practice environments have higher reported safety perceptions and patient outcomes.

Practice environment and job satisfaction. Nurse job satisfaction is a subjective variable, which can be directly impacted by many factors. The concept is complex and multifaceted and is defined differently by different individuals. In a concept analysis by Castaneda and Scanlan (2013), antecedents to job satisfaction were defined as practice environment and individual characteristics of the nurse, with defining attributes as autonomy, interpersonal relationships, and patient care. With job satisfaction tied to the practice environment, nurse productivity and patient outcomes, research exploring the associations between job satisfaction, and practice environment variables are important. Using the *National Database of Nursing Quality Indicators – Adapted Index of Work Satisfaction* (NDNQI-AIWS), Ramoo, Abdullah, and Piaw (2013) explored the relationship between job satisfaction and intention to leave current employment. The professional development subscale received the highest satisfaction score, with task, autonomy and professional status the next highest satisfaction (Ramoo et al., 2013).

Additionally, intention to leave was significantly predicted by job satisfaction after controlling for demographic variables (Ramoo et al., 2013).

Low job satisfaction has been associated with poor quality of performance, work related stress, and the perception of the practice environment (Hayes et al., 2010; Jelastopulu et al., 2013; McGlynn, Griffin, Donague, & Fitzpatrick, 2012; Wells, Manuel, & Cunning, 2011). Using the *NDNQI- Adapted Index of Work Satisfaction* and a job stress inventory, Jelastopulu et al. (2013) assessed how job satisfaction and job stress are associated. In a sample of 494 nurses working in various clinical units in five different hospitals, limited decision making opportunities, limited autonomy, and low manager support were associated with increased job related stress and low job satisfaction (Jelastopulu et al., 2013). Based on Herzberg's Motivation-Hygiene Theory, McGlynn, et al. (2012) expected a positive relationship between overall job satisfaction and a recent change in a professional practice model. Using the PES-NWI to assess the practice environment and the Index of Work Satisfaction, Part B(IWS-Part B) to measure job satisfaction, a statistically significant negative correlation was found between overall scores (McGlynn et al., 2012). This unpredicted result provides support to the importance the practice environment plays in job satisfaction and value in knowing what practice environment characteristics nurses desire. Table 1 summarizes recent research utilizing the NWI-R and versions of the IWS.

Summary

In summary, as patient-centered care becomes increasingly important to healthcare leaders, consumers, and those providing the care, incorporating caring measures which are patient-focused and insightful will create opportunities for nurses to

really know their patients. Primary to a caring, patient-centered practice is knowing the patient, an element of practice which is essential to a patient feeling cared for and safe. Providing for a patient's clinical needs is enhanced by gaining personal knowledge about the patient and knowing the patient has been identified as a necessary element in developing a caring relationship (Swanson, 1991).

Currently there is limited research studying the patients' perception of feeling known by their nurses and how patients define feeling known. Additionally, despite an abundance of research exploring how the practice environment relates to patient and nurse outcomes, there is limited research regarding the relationship between the patients' perception of feeling known by their nurse and practice environment characteristics. This study will explore this gap in knowledge by evaluating the relationship between the patients' perception of feeling known by their nurses and the practice environment during an inpatient hospitalization. An adapted version of the Quality-Caring Model© will provide the conceptual model to inform this study (Duffy & Hoskins, 2003).

Table 1

Review of studies using the IWS and the NWI-R

Author/Journal	Setting/ Participants	Conceptual/ Theoretical Framework	Variables	Instruments and Psychometrics	Findings
Cho, Mark, Yun, and June (2011). Differences in intensive care unit work environments among and within hospitals using subscales and a composite measure of the Revised Nursing Work Index. *Journal of Advanced Nursing*	39 ICUs in 15 hospitals 817 Staff Nurses		Nurses' perception of the work environment	Revised Nursing Work Index (NWI-R) – reliability: alpha 0.57-0.89 for subscales, 0.80 for composite score.	Among both hospital and ICU there was considerable variation in subscale scores. Mixed environments (poor, moderate, good) were found in most hospitals and ICUs. There was not always congruence between the subscales scores and the composite scores
Clavelle, Porter O'Grady, & Drenkard (2013). Structural empowerment and the nursing practice environment in Magnet® organizations. *Journal of Nursing Administration*	Magnet Organizations 95 CNO's 107 Nurse Practice Council chairs	Kanter theory of structural determinants of power	Characteristics of the Nurses work environment Perception of governance	Index of Professional Nursing Governance (IPNG) – reliability: alpha 0.839- 0.908 for subscales, 0.959 for total IPNG. Nurses Work Index Revised (NWI-R) – reliability: alpha 0.623-.0787 for subscales, 0.93 for total NWI-R.	A highly significant positive relationship (r= 0.416, P<.001) was found between the total scores of the IPNG and the NWI-R. NWI-R subscale nursing autonomy was the most significantly correlated characteristic.
Mallidou, Cummings, Estabrooks & Giovannetti (2011). Nurse specialty subcultures and patient outcomes in acute care hospitals: A multiple-group structural equation modeling. *International Journal of Nursing Studies*	1937 Total RN's 564 in medical 608 in surgical 467 in intensive 298 in emergency	Martin's operational definition of organizational culture	Job Satisfaction Quality of Care Adverse Patient Events Control over Practice Autonomy RN-MD Relationships	Nursing Work Index – Revised (NWI-R) – reliability: not reported. Maslach Burnout Inventory (MBI) – reliability: alpha 0.90-0.91for emotional exhaustion subscale.	Control over practice as measured by the NWI-R increased job satisfaction in in the critical care and surgical specialties, in addition to having the significantly strongest association with quality of care.
Van Bogaert, Timmermans, Weeks, van Heusden, Vouters, & Franck (2014). Nursing unit teams matter: impact of unit-level nurse practice environment, nurse work characteristics, and burnout on nurse reported job outcomes, and quality of care, and patient adverse events – a cross sectional survey. *International Journal of Nursing Studies*	8 hospitals 96 Nursing Units 1201 Nurses		Nurse Practice Environment Nurse Work Characteristics (work load, decision latitude, social capital) Patient Adverse Events Job Outcomes	Nursing Work Index Revised (NWI-R) – reliability: not reported Maslach Burnout Inventory Human Services Survey (MBI HSS) – reliability: not reported	Nosocomial infections and medication errors were significantly associated with nurse-physician relations and management at both the unit and hospital level. Patient falls, nosocomial infections, and medication errors were significantly associated with emotional exhaustion and depersonalization.

Author/Journal	Setting/ Participants	Conceptual/ Theoretical Framework	Variables	Instruments and Psychometrics	Findings
Duffield, Roche, Blay & Stasa (2010). Nursing unit managers, staff retention and the work environment. *Journal of Clinical Nursing*	94 medical and surgical units in 21 hospitals 2488 nurses		Staff perceptions of nurse manager leadership characteristics Staff satisfaction Staff retention	Nursing Work Index – Revised (NWI-R) – leadership domain – reliability: alpha 0.80.	Results suggested high performing and positively rated units had Nurse Managers performing well on all 12 aspects measured in the leadership domain.
Ramoo, Abdullah & Piaw (2013). The relationship between job satisfaction and intention to leave current employment among registered nurses in a teaching hospital. *Journal of Clinical Nursing*	Public Teaching Hospital 141 nurses		Job Satisfaction Intention to leave	National Database of Nursing Quality Indicators – Adapted Index of Work Satisfaction (NDNQI-AIWS) – reliability: alpha 0.81-0.84 for subscales	The professional development subscale received the highest satisfaction score, with task, autonomy and professional status the next highest satisfaction. Additionally, intention to leave was significantly predicted by job satisfaction after controlling for demographic variables
Klaus, Ekerdt, and Gajewski , (2012). Job satisfaction in birth cohorts of nurses. *Journal of Nursing Management*	53,851 RN's age 20-59			NDNQI RN Survey® with Job Satisfaction Scales© - reliability: alpha 0.76 – 0.93 for subscales.	Significantly positive relationship was found between job satisfaction and quality of care across all age cohorts. Years on the unit had a significantly positive effect on the 40-49 and 50- 59 age cohorts but a significantly negative effect on the 20-29 age cohort.
Jelastopulu, Tsouvaltzidou, Vangeli, Messolora, Detorakis & Alexopoulos (2013). Self-reported sources of stress, job satisfaction and quality of care in professional hospital nurses in West-Greece. *Nursing and Health*	5 Hospitals, different clinical units 494 nurses		Job Satisfaction Self-reported stress Quality of care	NDNQI-Adapted Index of Work Satisfaction – reliability: alpha 0.84 for overall. Job Stress Inventory 9 work-contextual items related to quality of care.	Limited decision making opportunities, limited autonomy and low manager support were associated with increased job related stress and low job satisfaction
McGlynn, Griffin, Donahue & Fitzpatrick (2012). Registered nurse job satisfaction and satisfaction with the professional practice model. *Journal of Nursing Management*	4 Nursing Units 182 full and part-time nurses	Herzberg's Motivation-Hygiene Theory	Job Satisfaction Practice Environment Professional Practice Model	Index of Work Satisfaction, Part B (IWS-Part B) – reliability: alpha 0.77 for overall, 0.69-0.80 for subscales. Practice Environment Scale of the Nursing Work Index (PES-NWI) – reliability: alpha 0.85 for overall, 0.81-0.83 for subscales.	A statistically significant negative correlation was found between job satisfaction and the practice environment. RN had overall low job satisfaction on the units where a professional practice model was in place.

CHAPTER III

METHODOLOGY

This study explored the relationship between nurses practice environment in an acute care hospital and patients' perception of feeling known by their nurses. Relationships between demographic variables and the patients' perception of feeling known by their nurses were also explored for associations. In this chapter the research design, sampling methods, data collection procedures, measurement instruments, data analysis procedures, and protection of human subjects is described.

Research Questions

1. What is the relationship between the patients' perception of feeling known by their nurses and
    a. The nurses' perception of the practice environment?
    b. Patients' level of care (acute vs. progressive)?
2. Is there a difference in patients' perception of feeling known by their nurses based on level of care (acute and progressive)?

3. Are any demographic variables (age, race, gender, marital status, educational level, and days in the hospital) associated with patients' perception of feeling known by their nurses?
4. If any demographic variables are significantly associated, do these variables account for a significant amount of variance in the patients' perception of feeling known by their nurses?
5. How do hospitalized inpatients describe their feelings of safety, connection with the staff, feeling cared for, and inclusion in their care?
6. To what extent does the patients' perception of feeling known by their nurses agree with the data from the open-ended questions on the patients' perceptions of safety, connection, caring and inclusion in care?

Operational Definitions

The following operational definitions supported this study.

Table 2

Operational Definitions

Variable	Operational Definition
Personal connection	A shared consciousness and mutual partnership between the patient and their nurses
Unique human being	The patients' experience of nurses, who through purposeful interaction, gained insight into the people, events, history and experiences that were meaningful in shaping that individual
Felt safe	Patients having confidence in their nurses' intentions and abilities to advocate for their well-being, to act upon their concerns and to ensure that their needs were communicated effectively to all providers so that vital information is not lost

Participate in their care	The patients' experience of nurses who valued patients as knowledgeable partners in care and who provided information that helped patients make informed choices
Nurse Practice Environment	Practice setting characteristics, both organization wide and unit based, which constrain or facilitate professional nursing practice (Lake, 2002)
Nurse Perception of Practice Environment	Indicates the opinion regarding the practice environment and organization held by a nurse.
Patient-Centered Care	Care which is tailored to meet individualized patient needs
Job Satisfaction	The extent to which people like their job (Stamps, 1997)
Level of Care	Refers to the type of patient monitoring and amount of nursing care required. Care can be at the acute care level (1:5 patient ratio), progressive care level (1:4 patient ratio), or intensive care level (1:2 patient ratio).

Research Design

This study used a descriptive, correlational design to measure the relationship between the nurses' perception of their practice environment and the patients' perception of feeling known by their nurses. Additionally, relationships between the patients' perception of feeling known by their nurses and select demographic variables were explored. The patients' perception of feeling known during an inpatient hospitalization was explored using both quantitative and qualitative descriptive methods. Capturing patients' perceptions solely through quantitative methodologies limits the ability to thoroughly explore the complexity and limitations of a specific phenomenon (Polit & Beck, 2012). Different yet complementary types of data were collected on the same topic, thus allowing for a more complete understanding of the phenomenon (Creswell & Plano Clark, 2011). To confirm and validate the results from the *Patients' Perception of*

Feeling Known by Their Nurses Scale (PPFKN) survey, four structured open-ended questions were asked of patient participants to gain further insight into perceptions around the four subscale themes of the PPFKN. Subscale themes included experienced a meaningful, personal connection with their nurses, experienced being recognized as a unique human being, felt safe, and felt empowered by their nurses to participate in their care. The aim of the quantitative method approach was to describe the patients' perception of feeling known by their nurses during their inpatient hospitalization, including level of care differences as measure by PPFKN and the aim of the qualitative method approach was to determine the content validity of the PPFKN.

Setting

The setting for this study was a not-for-profit, ANCC Magnet® designated community hospital with 536 acute care beds. Inpatient acute and progressive levels of care were included for recruitment of potential study participants. The hospital has two acute care and four progressive care units for a total of 268 beds. Access to this site is possible because of current employment status by the investigator with this hospital.

Sample and Recruitment

Patients. A convenience sample of hospitalized adult patients on acute or progressive levels of care unit were recruited for inclusion in this study. Eligibility to participate included the following criteria: patients 18 years of age or older on the day of or day before anticipated discharge with a hospital admission time of at least 48 hours, no change in level of care or nursing care unit, able read and write in English, and felt well enough to participate in the data collection.. Included patients were alert and oriented

and had the ability to provide informed consent and actively participate in the survey process. Exclusion criteria were any patient not meeting inclusion criteria.

Recruitment. Each day the pending discharge report in the hospitals bed-tracking system was used to screen for participants meeting inclusion criteria. The assigned nurse for each potential patient participant was then approached for further screening to assure patients were appropriate for participation. Patients meeting inclusion criteria were approached by the patient's direct care nurse or the charge nurse, and given a flyer promoting the opportunity to participate in the study. Patients expressing interest in participating were approached by the principle investigator (PI) and presented with the details of the study. Recruitment continued until an adequate sample size was reached.

Power, effect, and sample size. To increase the ability to detect a relationship among the study variables and achieve adequate statistical power, several methods of determining sample size were evaluated (Polit & Beck, 2012). To determine an adequate sample size for each research aim, an alpha of .05, a power of .80, to minimize a type II error, and a moderate effect size were used. A moderate effect size for correlation is r = .30 (aim #2 and #4), for t-test is d = .50 (aim #3), and for multiple regression is R^2 = .13 (aim #5) (Polit, 2010). Sample size was determined *a priori* using two methods, G*Power on-line calculator (Faul, Erdfelder, Lang and Buchner, 2009) and sample size tables from Polit and Beck (2012). Sample size was determined for each type of analysis planned, including correlation (aim #2 and #4), differences between groups (t-test) (aim #3), and multiple regression (aim #5). Table 3 shows sample size calculations for the three aims. Sample size estimate for T-test was the largest, indicating a sample of 64 patient participants required for each group or level of care.

Table 3

A priori sample size calculations

	Polit & Beck	G*Power 3.1.6
Correlation	85	NA
T-test	128 (64 each group)	128 (64 each group)
Multiple Regression	104	118

Nurses. Annually, a hospital wide RN satisfaction survey is completed at this participating research site. Convenience samples of full-time, part-time, and per diem registered nurses, who spend at least 50% of their time in direct patient care, are invited to participate in the annual survey. Permission to use data from the RN satisfaction survey was obtained from the Chief Nursing Officer prior to use in this study. Participating organizations receive survey results from National Database of Nursing Quality Indicators® about two months after the completion of data collection. Once received, the organization places all results in a shared file accessible to organization leadership so access is readily available and convenient.

Measurements

This study utilized one patient data collection instrument and a demographic questionnaire for the collection of patient data, and nurse data provided by the organization. The demographic questionnaire was included in the *Patients' Perception of Feeling Known by their Nurses Scale* (PPFKN). Patient demographic information included age, race/ethnicity, gender, marital status, education, and number of days in

hospital during current visit. Patient's current level of care (acute or progressive) was noted on the survey prior to distributing to the patient.

The patients' perception of feeling known by their nurses scale. Patients' perception of feeling known by their nurses during an inpatient hospitalization was measured using the PPFKN. Utilization of findings from the PPFKN has the potential to create opportunities to influence such organizational outcomes as patient satisfaction and safety in addition to enhancement of the nurse-patient relationship (Somerville, 2009a).

The PPFKN was developed by Somerville (2009a) to assess the impact of the healthcare environment on the patient experience. To describe the phenomenon of patients' feeling known by their nurses a qualitative descriptive study was completed in 2003 with surgical inpatients (Somerville, 2009b). From this research, four themes emerged to describe patients' feelings known by their nurses including the following: 1) experienced being recognized as a unique human being, 2) felt safe, 3) experienced a meaningful, personal connection with their nurses, and 4) felt empowered by their nurses to participate in their care (Somerville, 2009a). Initially an 85-item scale, guided by the four themes, was developed. A panel of nurse and patient experts reviewed the 85-items for content validity, readability, and understandability. A four component, 77-item scale resulted from this review.

The revised 77-item PPFKN scale was administered to 327 surgical patients in seven different nursing units on their day of discharge. Inclusion criteria consisted of adult surgical patients between the age of 18 and95 who were able to read English and consent to participate. Thirty-one surveys had incomplete data and were dropped from the analysis leaving a total of 296 completed surveys available for analysis (Somerville,

2009b). Using SPSS, version 15.0, item-total correlations were computed for all items. An initial Cronbach's alpha coefficient of 0.99 was found for the 77-item scale. Many items had an inter-item correlation of >0.7, indicating some redundancy within items, however based on the principal-components analysis (PCA) all items were retained (Somerville, 2009b). After subjecting the PPFKN Scale for the 296 participant responses to PCA with iterations, Varimax rotation, and Kaiser normalization, 29 items were dropped from the scale resulting in a reliable and valid 48-item scale with a 0.98 total Cronbach's alpha coefficient (Somerville, 2009b).

The PPFKN scale consists of 48-items organized around four themes. Each item is a closed-ended declarative statement on a 4-point Likert scale, 1 = strongly disagree to 4 = strongly agree (Somerville, 2009b). Cronbach's alpha coefficients for each of the four subscales range from .90 to .96 (Table 4).

Table 4

Patients' Perception of Feeling Known by their Nurses Scale Reliability of Subscales

Subscale	Number of Items*	Cronbach's Alpha Coefficient*
Experienced a Meaningful, Personal Connection with Their Nurses	17	.96
Felt Safe	8	.90
Experienced Being Recognized as a Unique Human Being	15	.93
Felt Empowered by Their Nurses to Participate in Their Care	8	.92

* Somerville, 2009b

The PPFKN items are scored on a 4-point Likert scale with 4 = strongly agree, 3 = agree, 2 = disagree, and 1 = strongly disagree. The Likert scale is designed so the high

scores represent high amounts of the construct being measured (Somerville, 2009b). Items corresponding to each of the four subscales are randomly placed throughout the survey so the participant is unaware of any connection from one item to another. Since the subscales have unequal numbers of items, average scores are used to create an equal weighting for each subscale. For cases with more than 10% missing data it is recommended to drop the case, if missing data is less than 10%, a substitution with item mean or median may be used (Somerville, 2009a).

Since Somerville developed the PPFKN in 2009, studies using it have not been published in the literature. The initial psychometric properties of the PPFKN were promising; however the lack of additional research to test the reliability of the instrument is a limitation for wide applicability of results. Since participants in the original study were primarily white, well-educated, married, surgical patients, further research is needed on more diverse patient populations and settings. Additionally, due to the limited demographics of the original study population used in the development of the PPFKN, further questioning through qualitative means from additional patient populations may either assist in further illustrating the quantitative results or provide additional understanding and insight into this phenomenon.

Supplemental survey. Each survey packet contained a supplemental survey designed to determine content validity of the PPFKN. This survey will include four structured, open-ended questions addressing each of the four PPFKN subscale themes (Table 5). Subscales include the following: 1) experienced being recognized as a unique human being, 2) felt safe, 3) experienced a meaningful, personal connection with their nurses, and 4) felt empowered by their nurses to participate in their care. Open-ended

questions were created with support from existing literature on each of the four subscale themes.

Table 5

Supplemental Survey Questions

Questions	Readability
1. Explain how the staff have made a connection with you during this hospitalization.	
2. What have we done that helped you to feel ease cared for?	Flesch readability = 75.9
3. Describe your feelings of safety during this hospitalization.	Flesch-Kincaid grade level = 5.3
4. Explain how the staff have included you in your care?	

NDNQI® RN survey with job satisfaction scales-R. The nurses' practice environment at this participating research site is assessed annually through participation in the National Database of Nursing Quality Indicators (NDNQI) annual RN survey. The RN survey utilizes the NDNQI® *RN Survey with Job Satisfaction Scales-R* instrument. This survey contains selected items from the *NDNQI-Adapted Nursing Work Index* (Aiken & Patrician, 2000) and the *NDNQI-Adapted Index of Work Satisfaction* (Stamps, 1997; Taunton et al., 2004).

The original *Index of Work Satisfaction* was developed by Stamps in 1972 to measure nurses' job satisfaction and to obtain a better understanding of the nurse practice environment (Stamps, 1997). The original index was a 48-item questionnaire with six subscales: Pay, professional status, task requirements, autonomy, interaction, and

organizational policies (Stamps, 1997). After multiple revisions, the final validation study produced a 44-item questionnaire with seven subscales: Pay, professional status, task requirements, autonomy, nurse-physician interaction, nurse-nurse interaction, and organizational policies (Stamps, 1997).

Quality indicators collected and analyzed by NDNQI® are at the patient care unit level; hence it is logically congruent to focus nurse satisfaction at this level. To support unit level nurse satisfaction scoring, NDNQI® staff sought permission from Dr. Stamps to adapt the *Index of Work Satisfaction* from an individual RN focus to a RN work group (unit) focus. Additionally, several index items were revised to remove extraneous verbiage and separate multiple concepts (Taunton et al., 2004). Two different national samples of RNs were used to explore the effect of changing the index focus from individual to work group. Confirmatory factor analysis was used to confirm dimensionality of the adapted version of the index. Using structural equation modeling, Taunton et al., (2004) confirmed the *NDNQI® –Adapted Index of Work Satisfaction* as a seven-factor structure (CFI [719] = .88; RMR = .05) including Nurse-Nurse Interaction, Nurse-Physician Interaction, Task, Autonomy, Professional Status, Pay, and Decision Making. Internal consistency reliability for all subscales, except professional status, was acceptable (Cronbach's α = .74 - .91) (Taunton et al., 2004).

The original 65 item *Nursing Work Index* (NWI) was developed to measure nurses' job satisfaction and perception of care quality. With content ideal for the development of a new instrument, Aiken and Patrician (2000) created the *Revised Nursing Work Index* (NWI-R) to measure aspects of the professional practice environment. In the NWI, nurses' were asked to respond to two value statements and one

presence statement for each item (Kramer & Hafner, 1989). In the NWI-R, the value statements were eliminated in order to create a measure of an organizational trait versus an individual characteristic (Aiken & Patrician, 2000). After conceptually evaluating the original 65 NWI items for importance to a professional practice environment, 55 were retained, one item was added and one item was modified (Aiken & Patrician, 2000). Four subscales were conceptually derived to form the NWI-R and measure the professional practice environment: autonomy, control over practice, nurse-physician relationship, and organizational support (Aiken & Patrician, 2000). Resulting group level internal consistency reliability was good, with an overall Cronbach's alpha of .96 for the entire NWI-R, and subscale alphas between .84 and .91(Aiken & Patrician, 2000).

The current version of the *NDNQI® RN Survey with Job Satisfaction Scales-R* was created from a revised form of the *NDNQI®-Adapted Job Satisfaction Scales* (NDNQI, 2014). In order to streamline the measure, the current version has a reduced number of items per subscale. Presently there are 11 subscales, three questions per subscale for a total of 33 questions. Subscales include Task, Nurse-Nurse Interaction, Nurse-Physician Interaction, Decision Making, Autonomy, Professional Status, Pay, Professional Development Opportunity, Professional Development Access, Supportive Nursing Management, and Nursing Administration (NDNQI, 2014). The *NDNQI® RN Survey with Job Satisfaction Scales-R* items are scored on a 6-point Likert scale with 6 = strongly agree, 5 = agree, 4 = tend to agree, 3 = tend to disagree, 2 = disagree and 1 = strongly disagree. The Likert scale is designed so high scores represent more agreement regarding presence of subscales in the current job situation. All individual responses on the *RN Survey with Job Satisfaction Scales-R* are aggregated to the unit level by NDNQI® prior

to releasing to the participating organization. Table 6 summarizes the dependent and independent variables and the measurement tool for each variable.

Table 6

Dependent and Independent Variables

Variable	Measurement Tool	Instrument Details
Dependent		
Patient Perception	PPFKN	48 Items Four Subscales Four point Likert Scale
Independent		
Nurse Perception	Job Satisfaction Scales-R	33 Items Eleven Subscales Six point Likert Scale
Level of Care Acute Care Progressive Care	Demographic Questionnaire	
Age	Demographic Questionnaire	
Race/Ethnic Origin		
Gender		
Marital Status		
Education		
Number of days in Hospital		

Procedure

Prior to beginning patient data collection, contact was made with all nurse leaders from inpatient units included in the study. Informational flyers informing unit-based employees about the study were provided to the nurse leader of each unit to assist in informing staff of potential recruitment of their patients into the study. Once potential participants were recruited, the investigator approached the participant, introduced

herself, and confirmed agreement to learn more about the study. If the participant was agreeable, the investigator provided informed consent according to human subject protection requirements, assuring the participant had adequate information regarding the study, fully understood the information received, and had the ability to voluntarily consent or decline participation (Polit & Beck, 2012).

Patients. Patients meeting inclusion criteria and agreeing to participate were provided a study packet. Each packet contained a cover letter, outlining the study, the risk and benefits in participating, the plan for confidentiality, the PPFKN survey, which included a demographics questionnaire, and the supplemental survey. Each participant was offered the option of completing the surveywith or without the assistance of the researcher. Time to complete the surveys varied from patient to patient, with the average time to complete about 20 minutes. The patient's level of care and unit was noted on each survey prior to leaving the survey packet. An envelope was included in the survey packet for securing the surveys after completion. All packets were collected by the researcher prior to the patient discharging home. Returned surveys were sequentially numbered upon collection. All subject contact and survey completion assistance was performed by the principle investigator for consistency in the data collection process. Completed surveys were kept in the principal investigator's locked office in a separately locked file cabinet. There was no risk of identification since there were no direct identifiers on the surveys.

Nurses. As background, all nurses meeting inclusion criteria within the organization annually voluntarily complete the *NDNQI® RN Survey with Job Satisfaction Scale-R* through on-line computer access. Nurses are recruited by the organization via

flyers posted within the nursing unit, email announcements, unit announcements and meetings, and signs placed on all clinical documentation computers with the link for the survey. Nurses are provided time on duty to complete the survey or if desired the survey could be completed at home at their convenience. Consent is implied through the completion and submission of the on-line survey. To encourage survey completion, weekly hospital-wide progress statistics are posted by hospital leadership in each unit to elicit unit-to-unit competition. Unit based incentives are given each week to participants completing the survey. A hospital-wide incentive, iPad Mini, has been given to a randomly drawn participant based on survey participation receipts turned in to unit leadership. Survey period lasts three weeks. Results of the survey are received by the organization from NDNQI® about 60 days after data collection closed.

Data Analysis

Both quantitative and qualitative methods were used to analyze the data from this study. The quantitative and qualitative data was collected simultaneously, and analyzed separately with the results from each analysis compared to either confirm or disconfirm each other (Creswell, 2014).

Quantitative data analysis. Quantitative data analysis was conducted using the SPSS (SPSS Inc. Chicago, IL, USA) version 21 software. Data was examined by entire database and then grouped by unit type (acute and progressive care) and examined with descriptive statistics. Descriptive statistics included mean, standard deviation, and percentages of all patient demographics and PPFKN subscales. Internal consistency reliability of the PPFKN was evaluated using Cronbach's alpha for overall instrument and at each subscale level. Cronbach's alpha coefficients between .70 - .75 are

considered adequate at the subscale level, but coefficients equal to or greater than .80 are highly desirable (Polit, 2010). To determine if there were differences between acute and progressive levels of care, T-tests were calculated to compare unit type PPFKN mean scores for each subscale and overall score. The relationship between the patients' perception of feeling known and the level of care, acute or progressive, was evaluated with Point Bi-serial correlation. The point-bi-serial correlation coefficient summarizes the direction and strength of a relationship between an interval or ratio level variable and a dichotomous nominal level variable (Polit, 2010).

Data from the *NDNQI® RN Survey with Job Satisfaction Scale-R* (JSSR) was obtained for each nursing unit as a mean aggregate score for each subscale and overall score from NDNQI®. The relationship between the nurses' perception of the practice environment and the patients' perception of feeling known was analyzed using Mixed Linear Modeling (MLM). In the model, patients were nested within individual patient care units, with patient data a Level 1 unit and unit based nurse data a Level 2 unit. Patients' perception of feeling known was entered into the model as the dependent or outcome variable, and the unit based JSSR mean score was entered as a covariate. Any level of hierarchy can define the variables used in the model and MLM allows group characteristics to be included in models of individual outcomes (Hox, 2010).

Bivariate correlational statistics were used to determine whether a relationship existed between demographic variables and the patients' perception of feeling known. Ratio level variables, age, educational level, and number of days in the hospital, were explored using Pearson's *r* correlations and nominal level variables, gender, race/ethnicity, and marital status, were explored using Point Bi-serial correlations. A

linear regression analysis was performed to determine the amount of variance explained by all statistically significant demographic variables. Research questions, instrument to measure each variable, level of measurement, instrument reliability, and statistical test to measure each research question are presented in Table 7.

Table 7

Statistical Analysis

Research Questions	Instrument Variables	Level of Measurement Reliability	Analysis
1. What is the relationship between the patients' perception of feeling known by their nurses and	PPFKN Patient Perception (DV)	Interval Cronbach's alpha .98	
a. the nurses perception of the practice environment	Job Satisfaction Scales-R	Interval	Mixed Linear Modeling
b. patient's level of care (acute vs. progressive)?	Nurse Perception (IV) Demographic Level of Care (IV)	Nominal	Point Biserial
2. Is there a difference in patients' perception of feeling known by their nurses based on level of care (acute vs. progressive)?	PPFKN Patient Perception (DV) Demographic Level of Care (IV)	Interval Nominal	T-test
3. Are any demographic variables (age, race, gender, marital status, educational level, and days in the hospital) associated with patients' perception of feeling known by their nurses?	Demographic Age Race Gender Marital Status Educational Level Number of days in hospital	Ratio Nominal Nominal Nominal Ratio Ratio	Pearson's *r* Correlation (Ratio data) Point Biserial (Nominal data)
4. If any demographic variables are significantly associated, do these variables account for a significant amount of variance in the patients' perception of feeling known by their nurses?	Significant demographic variables (IV) Patient Perception (DV)		Linear Regression

Supplemental survey data analysis. Data from open-ended patient questions were transcribed verbatim from each survey and entered into an excel file. All data were analyzed within apriori domains (PPFKN subscale topics) using principles of content analysis for determination of core meaning and identification of themes and patterns. Qualitative data analysis allows for further explanation of results from quantitative data analysis (Creswell, 2014). An on-line web-based secure data analysis program, Dedoose, was used for analyzing the data from the open-ended survey. Using content analysis, repetitive codes for each domain were allowed to emerge. Codes for each response were then reviewed and consolidated into similar themes or categories. Once code consolidation occurred, codes were then further grouped into like themes and given a category name. Each category consisted of two to six codes or subcategories. Once final codes were determined, data were analyzed via Dedoose through review of code frequency and the co-occurrence of two codes together.

After the quantitative and qualitative data analysis was complete, results from each subscale- specific question on the supplemental survey was matched to confirm alignment with the PPFKN items. The results of the quantitative and qualitative data analysis were compared to validate the content of the PPFKN subscales. Through comparison, an interpretation of how the results are connected, and/or explain, confirm, or validate the results can occur (Creswell & Plano Clark, 2011).

Protection of Human Subjects

Institutional review board approval was obtained from both the participating hospital and the University. Participation in the survey process was voluntary. Participants were given a summary of the study, including study purpose, research

methodology, why they are being asked to participate, projected time commitment, potential benefits and risks of this study, means that will be employed to ensure security and confidentiality of the data, the researcher's contact information, and contact information of the participating hospital and the University's Institutional Review Boards. There was no cost to participate, other than time to fill out the surveys. Participants were not paid for completion of the survey. Participants had the opportunity to ask questions prior to participating in the study. Patient participants were not required to sign an informed consent prior to any data collection.

Risks and Benefits

Any risk or benefits to patients participating in this study were considered minimal. There was a potential risk of participant burden related to the time required to fill out the PPFKN or complete the additional supplemental survey. All participants were offered the opportunity for the investigator to assist with the data collection process and/or write the information on the supplemental survey. If the burden became too great or the participant was unable to continue, the data collection process was terminated. There was an additional risk related to the patient's potential concern regarding anonymity of survey responses. Patients may worry if unfavorable responses had been given on the surveys there would be retaliation. All patients were informed about privacy protection during the informed consent process and no patients express concern. Potential benefit to patient participants included the opportunity to provide insight into specific care giver behaviors contributing to feeling known by their nurses.

Potential risk and benefit to nurses participating in the *NDNQI® RN Survey with Job Satisfaction Scales-R* data collection are also minimal. The opportunity to provide

the organization input regarding the practice environment where they work was a potential benefit to the nurses completing the survey. Nurse concern regarding the potential for management to have access to individual survey results was also a potential risk.

There was minimal overall risk to the organization in allowing this research study to be completed. However, potentially the organization did benefit from the information obtained from the study findings. Findings from this studyprovided insight into patients' perceptions of the care they have received and provided additional knowledge for improving care to patients by nursing staff.

Limitations

Several limitations warrant addressing related to this study. All patient data were collected from patients who were still in active care prior to discharge. Although all patients were assured anonymity and no patient identifiers were included, patient fear of confidentiality could have potentially affected survey responses. Additionally, most unit-based registered nurses caring for these patient participants were knowledgeable of the study being conducted on their unit. This knowledge may have influenced the nurses' efforts toward connecting with and knowing their patients.

Since the principle investigator was a current employee, in a leadership position, this could potentially have affected survey responses, especially in regards to the validity of the survey data. Additionally, almost half (48%) of the patient's requested investigator assistance in completing the survey and this direct assistance may have influenced how a patient responded to the survey and the structured questions. However, an additional

analysis demonstrated that there was not a significant difference between investigator assisted and self-completion groups ($t(120) = -.900$, $p > .05$).

This is the first known published study utilizing the *Patients' Perception of Feeling Known by their Nurses Scale* (PPFKN) and the initial instrument validation study was completed on a primarily white, well educated, married, surgical population. Even though this study's participant sample was recruited from a more diverse patient population, it is not known (due to variable not collected) what medical reason for hospitalization was applicable to this sample. Patient demographics did demonstrate some diversity; however, this study's population was also primarily white.

During the evaluation and coding of the content validity survey data, similarities were noted related to the wording of the items and the words used by patients to answer the questions. Although patients were not given a specific instruction to complete one data collection form before the other, the order of presentation to the patient by the PI was the same every time and it is assumed that most participants completed the PPFKN prior to the content validity survey. Based on this assumption, one cannot determine the level of influence the completion of the PPFKN had on patient responses on the content validity survey. Reflecting on the close alignment and degree of confirmation between the PPFKN subscale items and the categories and subcategories revealed from the content validity survey, it can be assumed there was some degree of affect.

Summary

This research study explored the relationship between the patients' perception of feeling known by their nurses and the nurses practice environment. Development of patient-centered models of care has become an important aspect of high quality and safe patient care. In order to further understand what specific elements of the nurse's practice environment contributes to high quality and safe patient care, organizations will need to explore how the practice environment and patients' perceptions of the quality and safety are tied. By exploring the relationship between the patients' perception of feeling known by their nurses and the nurses' practice environment, new knowledge on how these concepts contribute to patient-centered care and the development of therapeutic relationships can be discovered.

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CHAPTER IV

Manuscripts

Aim # 1	Examine the concept "feeling safe" through a concept analysis procedure
Manuscript #1	Feeling Safe During an Inpatient Hospitalization: A Concept Analysis
Aim #2	a. To describe the relationship between the nurses' perception of their practice environment and the patients' perception of feeling known by their nurses during their inpatient hospitalization. b. To describe the relationship between the patients' perception of feeling known by their nurses during their inpatient hospitalization and level of care (acute or progressive).
Aim #3	To describe the differences in the patients' perception of feeling known by their nurses by level of care.
Aim #4	To describe the relationship between patients' perception of feeling known by their nurses and select demographic variables (age, race, gender, marital status, education level, and number or days in the hospital)
Aim #5	To determine which select demographic variables account for a significant amount of variance in the patients' perception of feeling known by their nurses
Manuscript #2	The Influence of the Nurse Practice Environment on Patients' Perception of Feeling Known During an Inpatient Hospitalization

Aim #6	To further describe patients' perceptions of safety, connection, caring and inclusion through analyses of themes and patterns from data obtained from supplemental questions
Aim #7	To expand understanding of the patients' perception of feeling known by their nurses through validation of PPFKN results with the results of the supplemental questions
Manuscript #3	Expanding Understanding of the Patients' Perception of Feeling Known: A Validation Study

Manuscript #1

Feeling Safe During an Inpatient Hospitalization:

A Concept Analysis

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Mollon, D. (2014). Feeling safe during an inpatient hospitalization: a concept analysis. *Journal of Advanced Nursing, 70,* 1727-1737. doi:10.0000/jan.12348

Manuscript Summary

Feeling safe during an inpatient hospitalization is important to patients, and to patients, feeling safe may be much different than being safe. However, as people work at all levels of health care to improve the safety and quality of care, is it really known what it means to the patient to feel safe? Exploring the concept feeling safe will provide further understanding of this multi-faceted, complex phenomena leading to an improved understanding of the connection to patients perception of feeling known.

This concept analysis explores the critical attributes of the concept "feeling safe" from the patients perspective during an inpatient hospitalization. Using Walker and Avant's eight step method the concept of feeling safe was analyzed. Years 1995 through 2012 were searched using the terms safe and feeling safe in CINAHL, Medline, PsychInfo, and Goggle Scholar data bases.

The analysis identified four attributes of feeling safe, including trust, cared for, presence and knowledge. Concept antecedents include relationship, environment and suffering, and consequences are control, hope and relaxed or calm. Finally, the concept feeling safe is defined as an emotional state where perceptions of care contribute to a sense of security and freedom from harm. This analysis explores and synthesizes qualitative research already completed around the concept of feeling safe and begins early development of a theory of feeling safe.

Manuscript #2

The Influence of the Nurse Practice Environment on Patients' Perception of Feeling Known During an Inpatient Hospitalization

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To be submitted to International Journal of Nursing Studies

Abstract

Problem Statement: Historically, patient care has been provided based on personal experience, cultural norms, and basic assumption of consumer need. To improve the healthcare experience, healthcare providers must develop patient-centered care delivery models. Healthcare leaders have a responsibility to understand the connection between healthy practice environments and patients' perceptions of care. To date the perception of the patient is a key variable often missing in research.

Objective: To explore the relationship between the nurses' perception of the practice environment and the patients' perception of feeling known by their nurses, including level of care differences (acute and progressive care).

Methods: A descriptive, correlational study conducted in a 536 bed hospital on six patient care units (four progressive and two acute). Patients (N = 123) completed the *Patients' Perception of Feeling Known by their Nurses Scale* and a supplemental survey. The survey measures the impact of the healthcare environment on the patient experience and the phenomena of feeling known. Measuring registered nurse satisfaction at the unit level (N = 6), nurses completed the National Database of Nursing Quality Indicators *RN Survey with Job Satisfaction Scales-R.*

Results: Patients' perception of feeling known by their nurses measured a mean of 3.5 out of 4.0. No significant differences between levels of care were found for total score or individual subscale scores. A negative, significant correlation was found between the "Felt Safe" subscale and level of education ($r(121) = -.21$, $p<.05$). Nurses overall had favorable satisfaction at 4.37 on a 6 point scale. Nesting patients within individual nursing units, mixed linear modeling for the relationship between job satisfaction and patients' perception of feeling known was non-significant ($t(4) = -1.085$, $p > .05$).

Conclusion: This study did not confirm the practice environment has a positive or negative effect on the perception of feeling known. Findings begin to make visible the perceptions of patients and provide insight for development of patient care environments that promote patient- centeredness and the perception of feeling known.

1. Introduction

1.1. Problem Statement

Nurses are the primary provider of care at the bedside, and play a pivotal role in helping patients understand their healthcare experience and to communicate their values and beliefs to the healthcare team. However, historically nurses have provided care based on personal experience, cultural norms, and basic assumptions of consumer need. For care to be safe, effective, and patient-centered, therapeutic relationships must be developed between the nurse and the patient. In order to improve and change care delivery models, the perceptions of patients regarding their healthcare experience should be explored and investigated. Specific examination of the patients' perception of feeling known by their nurses may advance the nurse-patient relationship and safety during an inpatient hospitalization.

In order to build a patient-centered culture and promote the patients' perception of feeling known, the environment in which nurses and other healthcare providers practice is of critical importance. With increasing regulation and patient advocacy groups mandating and supporting patient-centered models of care, comes the need for radical change in the models of care delivery and the culture surrounding the delivery of care. Healthcare leaders have a responsibility to develop a thorough understanding regarding the connection between healthy practice environments and patients' perceptions of care, so practice environments supporting patient-centered care delivery can be created to improve the patients' healthcare experience.

While the link between the practice environment and patient outcomes has been well researched, the perception of the patient is a key variable often missing in research completed to date. Additionally, the literature addresses the barriers to building

therapeutic relationships and connecting with individual patients while in intensive care settings (Crocker & Scholes, 2009; Vouzavali et al., 2011), however, little research has addressed the difference between acute care and progressive care (step down) levels of care. This study addresses these gaps by exploring the relationship between the nurses' perception of the practice environment and the patients' perceptions of feeling known by their nurses, taking into consideration level of care and select demographic variables.

1.2. Conceptual Framework

Understanding how the practice environment influences the nurse's ability to develop therapeutic nurse-patient relationships, and how these relationships impact the patients' perception of feeling known ultimately affects the patient's experience of care and the outcomes from the care provided. This study is informed by a conceptual framework of the patient's experience of care through the development of a therapeutic nurse-patient relationship and will be supported by an adapted version of the Quality-Caring Model© developed by Duffy and Hoskins' (2003). This model links conceptually and theoretically Watson's (1988) human caring paradigm with Donabedian's (1966) structure, process and outcome paradigm, providing a mid-range model for clinical practice and research application. Under the structure component is the patient and the nurse, reflecting the causal past factors of unique attributes, demographics, and for the nurse attitudes and behaviors. The process component's primary focus is on the therapeutic, discipline-specific, independent relationship between the patient and the nurse. Lastly, in the third component, outcomes, the study variables of the patient's experience of care (perception) and the nurse practice environment perception and job satisfaction are included (Figure 1).

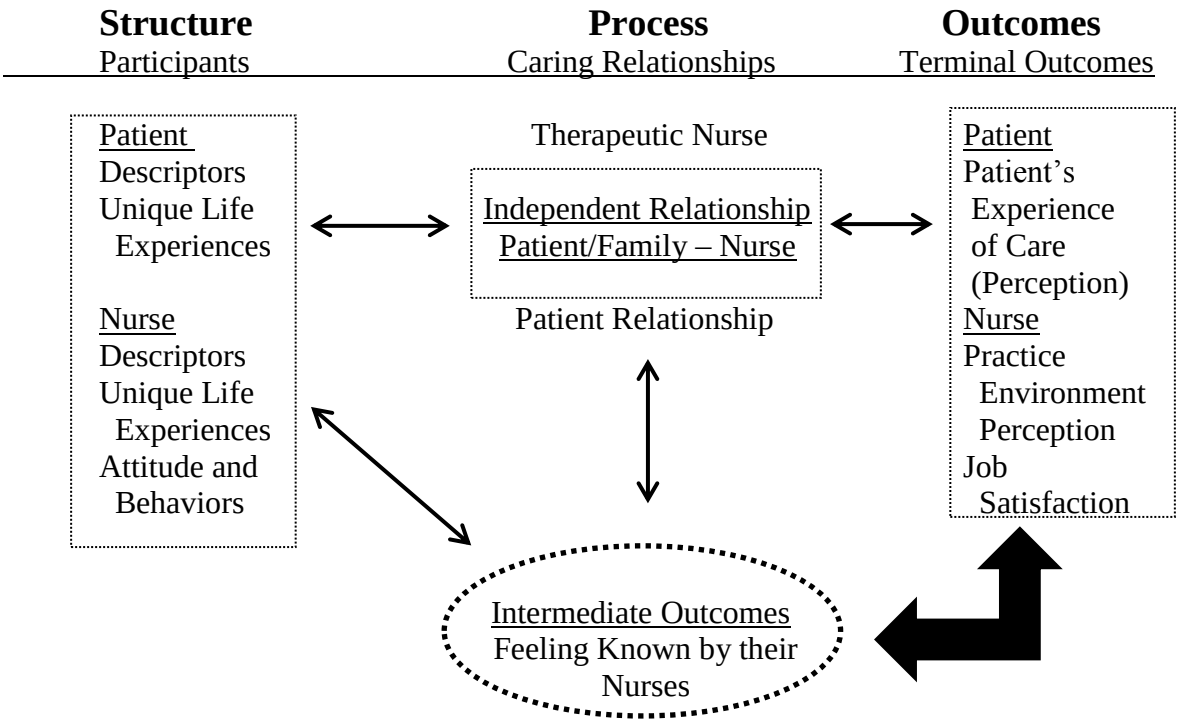

Figure 1: Adapted Quality-Caring Model© (Duffy, 2009).

The relationship-centered focus of the Quality-Caring Model© preserves the caring features associated with the professional nurse. Relationships based on caring contribute to positive health care outcomes and incorporate the phases of knowing, connection and interaction (Duffy, 2003). Through interaction with the patient, the nurse develops a connection which is a precursor to knowing (Duffy, 2003). This connection creates a sense of security which leaves the patient feeling cared for and safe. Creating a caring relationship with the patient generates a knowing of the other which allows the nurse to better assure safety of the patient, decrease their stress, and improve satisfaction with care (Duffy, 2003). In this study, the intermediate outcome of feeling known by their nurses is the main construct of interest.

1.3. Patients' Perception of Feeling Known

The importance and high level priority nursing places on knowing the patient has been well established. According to Polanyi (1958), knowing is holistic and personal and aims at finding reality through the process of aesthetics, science, and ethics. Through repeated interaction with patients, patient knowing develops, and the nurse-patient relationship strengthens. The degree of knowing the patient impacts the nurse's ability to individualize care and successfully make decisions regarding clinical treatments (Evans, 1996; Finch, 2004; Kelly, Doicherty, & Brandon, 2013; Mantzorou, 2011).

The consequences and effects of knowing the patient is not a new phenomenon for nursing and has been described throughout the literature over the decades. The literature has demonstrated a relationship between knowing and patient-centered care (Crocker & Scholes, 2009; Mantzorou, 2011), expert practice (Morrison & Symes, 2011), and patient safety (Beyea, 2006, Henneman et al., 2010). However, limited research has been conducted exploring the patients' perception of feeling known by their nurse. In work begun by Somerville (2009) the phenomena of patients' perceptions of feeling known by their nurses was supported by four themes. These four themes, used to describe the patients' perception of feeling known by their nurses, include: 1) experienced being recognized as a unique human being, 2) felt safe, 3) experienced a meaningful, personal connection with their nurses, and 4) felt empowered by their nurses to participate in their care (Somerville, 2009). Each of these four themes is an integral part of a patient-centered model of care, where the development of a therapeutic relationship and knowing the patient are key, critical elements in the care delivery process.

1.4. Practice Environment

If we are to develop and improve patient-centered models of care, we must create environments where nurses are empowered to have an active and dominate role in both unit and organizational level decision-making. With the complex and multi-faceted nature of the practice environment and the individuality required for specific patient populations and levels of care, practice environment measurement has been difficult and challenging. Multiple factors are known to influence healthy practice environments and are strongly supported in international research. Studies have associated positive staff and patient outcomes to practice environments which support staff empowerment, patient-centered care, shared governance, and a commitment to continuous quality improvement (Armellino, Griffin, & Fitzpatrick, 2010; Armstrong, Laschinger, & Wong, 2009; Clavelle, Porter O'Grady, & Drenkard, 2013; Donahue, Piazza, Griffin, Patricia, & Fitzpatrick, 2008; Rathert, Ishqaidef, & May, 2009; Rathert & May, 2007). Additionally, international research has demonstrated associations between the practice environment and leadership characteristics (Duffield, Roche, Blay, & Stasa, 2010; Thompson et al., 2011), patient satisfaction (Klinkenberg et al., 2011), quality of care (Aiken, et al., 2011; Eaton-Spiva et al., 2010; Van Bogaert et al., 2014), patient outcomes (Klaus, Ekerdt, & Gajewski, 2012; Mallidou, Cummings, Estabrooks, & Giovannetti, 2011), and patient safety (Kirwan, Matthews, & Scott, 2013; Squires, Tourangeau, Laschinger, & Doran, 2010).

Despite an abundance of research exploring how the practice environment relates to patient and nurse outcomes, there is limited research regarding the relationship between the patients' perception of feeling known by their nurses and practice

environment characteristics. This study explored this gap in knowledge by evaluating the relationship between the patients' perception of feeling known by their nurses and the practice environment during an inpatient hospitalization.

2. Methods

2.1. Design and sample

This descriptive, correlational study, using quantitative and qualitative methods, was conducted in a not-for-profit ANCC Magnet® designated community hospital with 536 acute care beds. Study participants were recruited from two acute and four progressive patient care units. Patient care unit sizes ranged from 33 to 41 beds and were staffed by registered nurses with support from nursing assistants. Acute care units consisted of non-monitored patients and nurse staffing of four or five patients to one nurse. Progressive care unit patients required more intensive monitoring with nurse staffing not to exceed four patients. This study entailed data collection from both patients and nurses in these units.

2.2. Measurement

2.2.1. Patients

A convenience sample of hospitalized English speaking adult patients, 18 years of age or older, on their day of or day before anticipated discharge with a hospital admission time of at least 48 hours and no change in level of care or nursing care unit were eligible to participate.

Patient data were collected from one primary instrument, the *Patients' Perception of Feeling Known by their Nurses Scale* (PPFKN), which included demographic questions. A supplementary questionnaire consisting of four questions related to the PPFKN

subscales were also included (Results of the supplemental questionnaire will be published in a future manuscript).

The *Patients' Perception of Feeling Known by their Nurses Scale* (PPFKN) (Somerville, 2009) was used to assess the patients' perception of feeling known by their nurses. This instrument was developed by Somerville in 2009 to assess the impact of the healthcare environment on the patient experience. The phenomena of feeling known is represented by four subscales including felt safe, experience being recognized as a unique human being, experienced a meaningful, personal connection with their nurses and empowered by their nurses to participate in their care (Somerville, 2009). The PPFKN scale is a 48-item instrument made up of closed-ended declarative statements scored on a four-point Likert scale ranging from strongly agree to strongly disagree. Demographics questions included age, race, gender, marital status, years of education, and number of days in the hospital. Cronbach's alpha coefficients for the four subscales range from .90 to .96 (Somerville, 2009).

2.2.2. Nurses

The nurse practice environment was assessed using the National Database of Nursing Quality Indicators® (NDNQI) *RN Survey with Job Satisfaction Scales-R* instrument. This annual, hospital-wide, RN satisfaction survey uses a convenience sample of full-time, part-time, and per diem RNs, who spend at least 50% of their time in direct patient care. The *NDNQI® RN Survey with Job Satisfaction Scales-R* contains selected items from the *NDNQI® -Adapted Nursing Work Index* (Aiken & Patrician, 2000) and the *NDNQI® -Adapted Index of Work Satisfaction* (Stamps, 1997; Taunton et al., 2004). The current version of the *NDNQI® RN Survey with Job Satisfaction Scales-R* was created from a revised form of the *NDNQI® -Adapted Job Satisfaction Scales*

(NDNQI, 2014). Presently there are 11 subscales, three questions per subscale for a total of 33 questions. Subscales include Task, Nurse-Nurse Interaction, Nurse-Physician Interaction, Decision Making, Autonomy, Professional Status, Pay, Professional Development Opportunity, Professional Development Access, Supportive Nursing Management, and Nursing Administration (NDNQI, 2014). The *NDNQI® RN Survey with Job Satisfaction Scales-R* items are scored on a 6-point Likert scale with 6 = strongly agree, 5 = agree, 4 = tend to agree, 3 = tend to disagree, 2 = disagree and 1 = strongly disagree. The Likert scale is designed so high scores represent more agreement regarding presence of subscales in the current job situation.

To increase confidentiality and assurance of anonymity, individual survey responses are not released by NDNQI® to participating organization. All survey responses are aggregated to the unit or workgroup level as a mean score and then standardized as T-scores. T scores less than 40 represent low levels of job satisfaction, scores between 40 and 60 represent moderate levels of job satisfaction and scores greater than 60 are high levels of job satisfaction.

2.3. Procedure

2.3.1. Patients

Leadership from each unit included in the study were contacted and informed of the study. Unit based staff were informed of the patient portion of the study via announcements at staff meetings and unit huddle meetings. In addition, informational flyers explaining the study were posted in unit conference rooms and informational bulletin boards. Each day the hospital bed-tracking system was used to screen for participants meeting inclusion criteria. The assigned nurse for each potential patient

participant was then approached for further screening to assure patients were appropriate for participation. Once potential participants were identified the investigator approached the participant, after introducing herself, the reason for contact and the details of the study were presented. If the participant was agreeable, the investigator provided informed consent according to human subject protection requirements, assuring the participant had adequate information regarding the study, fully understood the information received, and had the ability to voluntarily consent or decline participation. The study packet, containing the informed consent cover letter, data collection forms, a pen, and return envelope, were reviewed with the participant. Each participant was offered the option of completing the survey with the assistance of the principle investigator. Average time to complete the study was about 20 minutes. Each survey was sequentially numbered and the level of care and unit were added upon delivery of the questionnaire. Completed surveys were kept in the principal investigator's locked office in a separately locked file cabinet. Since there is no direct identifier on the survey there is no risk of identification to the subjects.

2.3.2. Nurses

Annually the study hospital voluntarily participates in the National Database of Nursing Quality Indicators (NDNQI®) RN satisfaction survey to evaluate the nurse practice environment as required by American Nurses Credentialing Center's Magnet Recognition Program®. All nurses' meeting NDNQI inclusion criteria volunteer to complete the *NDNQI® RN Survey with Job Satisfaction Scale-R* through on-line computer access. Nurses were recruited via flyers posted within the nursing unit, email announcements, unit announcements and meetings, and signs placed on all clinical

documentation computers with the link for the survey. Nurses are provided time on duty to complete the survey or if desired the survey could be completed at home at their convenience. Consent is implied through the completion and submission of the on-line survey. To encourage survey completion, weekly hospital wide progress statistics are posted by hospital leadership in each unit, to elicit unit to unit competition. Survey period lasts three weeks. Survey results are provided to the organization approximately 60 days after survey closes.

2.4. Data Analysis

Descriptive statistics, including frequencies, percentages, and mean scores, were used to describe the patient characteristics and evaluate for missing data. A total mean score, as well as a mean score for each subscale of the PPFKN was calculated. Internal consistency reliability of the PPFKN was evaluated using Cronbach's alpha for overall instrument and at each subscale level. Cronbach's alpha coefficients between .70 - .75 are considered adequate at the subscale level, but coefficients equal to or greater than .80 are highly desirable (Polit, 2010). To determine if there were differences between acute and progressive levels of care, T-tests were calculated for the PPFKN mean scores for each subscale and overall total score. The relationship between the patients' perception of feeling known and the level of care, acute or progressive, was evaluated with Point Bi-serial correlation. The point-bi-serial correlation coefficient summarizes the direction and strength of a relationship between an interval or ratio level variable and a dichotomous nominal level variable (Polit, 2010). To determine the relationship between patients' perception of feeling known by their nurses' and the nurses' perception of the practice environment, a mixed linear model was used. Nesting patients within patient care units, the patients' perception of feeling known by their nurses was entered into the

model as the dependent or outcome variable, while the nurses' job satisfaction mean score at the unit level was entered as a covariate. Mixed linear modeling allows group characteristics to be included in models of individual outcomes, and all variables can be defined at any level of hierarchy (Hox, 2012).

Bivariate correlational statistics were used to determine the relationship between demographic variables and the patients' perception of feeling known. Ratio level variables, age, educational level and number of days in the hospital, were explored using Pearson's *r* correlations and nominal level variables, gender, race/ethnicity, and marital status, were explored using Point Bi-serial correlations. A regression analysis was performed to determine the amount of variance explained by all statistically significant demographic variables.

2.5. Ethical considerations

Institutional review board approval was obtained from both the participating hospital and the University. Participants were given a summary of the study, including study purpose, research methodology, why they are being asked to participate, projected time commitment, potential benefits and risks of the study, means employed to ensure security and confidentiality of the data, the researcher's contact information, and contact information of the Institutional Review Boards. Participants had an opportunity to ask questions prior to participating in the study and were not required to sign an informed consent prior to any data collection.

3. Results

3.1. Participants

A total of 145 patients were approached to participate in this study. Of the 145, eight patients declined to participate upon approach from the researcher, and an

additional nine did not return their study packet after agreeing to participate. Overall, 128 packets were returned for a total of 64 patient participants from each level of care (acute and progressive). After completing a missing data analysis, five participants (four at acute and one at progressive levels of care) had missing data greater than 10%, so these files were eliminated. Additional files with less than 10% missing data were addressed through a person mean substitution approach. The demographic variables age and education were recoded from continuous variables into categorical variables for analysis. Additionally the race/ethnicity variable was collapsed from seven categories to four categories with Asian/Pacific Islander, Filipino, American Indian/Alaskan Native and other collapsed into an 'other' category. Mean age between groups (acute 58.3, progressive 62.5) was not statistically significant (p>.05), however years of education was statistically significant between the two groups (p =.01). Demographic characteristics of patient participants are presented in Table 1.

For the six participating study units, a total of 290 nurses had completed the *NDNQI® RN Survey with Job Satisfaction Scale-R* survey for an overall response rate of 80 %. Acute care had a lower response rate (74%) than progressive care (82%). Nurses on study units worked 12 hour shifts and had on average four patients at any one time. The percent of nurses planning to remain in direct patient care on same unit over the next year was 76.4% in acute care and 73.5% in progressive care. See Table 2 and Table 3 for individual unit participation rates.

Table 1

Characteristics of Patient Study Participants

Demographics Factors	Total % (n=123)	Acute Care % (n=60)	Progressive Care % (n=63)
Age			
Mean (Years)	60.4	58.2	62.4
25-40	8.1 (10)	10.0 (6)	6.3 (4)
41-50	15.4 (19)	16.7 (10)	14.3 (9)
51-60	25.2 (31)	30.0 (18)	20.6 (13)
61-70	23.6 (29)	20.0 (12)	27.0 (17)
71-80	18.7 (23)	20.0 (12)	17.5 (11)
81-90	8.9 (11)	3.3 (2)	14.3 (9)
Race			
White	70.7 (87)	71.7 (43)	69.8 (44)
Black	5.7 (7)	3.3 (2)	7.9 (5)
Hispanic	9.8 (12)	8.3 (5)	11.1 (7)
Other	13.8 (17)	16.7 (10)	11.1 (7)
Gender			
Female	50.4 (62)	56.7 (334)	44.4 (28)
Male	49.6 (61)	43.33(26)	55.6 (35)
Marital Status			
Single	20.3 (25)	18.3 (11)	22.2 (14)
Divorced	23.6 (29)	26.7 (16)	20.6 (13)
Widowed	10.6 (14)	8.3 (5)	12.7 (8)
Married/Living with Partner	42.3 (52)	45.0 (27)	39.7 (25)
Separated	3.3 (4)	1.7 (1)	4.8 (3)
Education			
Mean (Years)	14.0	14.7	13.4
No Diploma	5.7 (7)	5.0 (3)	6.3 (4)
High School Grad	32.5 (40)	28.3 (17)	37.5 (23)
Some College	37.4 (46)	31.7 (19)	42.9 (27)
College Grad	11.4 (14)	16.7 (10)	6.3 (4)
Post Grad	10.6 (13)	15.0 (9)	6.3 (4)
Missing	2.4 (3)	3.3 (2)	1.6 (1)

Table 2

PPFKN, JSSR, and JE Mean Scores by Unit

	Acute Care			Progressive Care		
	2 East	4 West	3 East	4 East	5 East	5 West
PPFKN*	n=28	n=32	n= 19	n=23	n=16	n=5
Mean	3.40	3.61	3.53	3.48	3.43	3.47
JSSR**	n=35	n=42	n=52	n=65	n=55	n=41
Mean	4.32	4.18	4.52	4.41	4.59	4.37
JE***	53.06	49.41	59.71	53.60	59.62	52.42

*PPFKN = Patients' Perception of Feeling Known by their Nurses Scale
**JSSR = NDNQI® RN Survey with Job Satisfaction Scale-R
***JE = Job Enjoyment

3.2. Patients' perception of feeling known

Cronbach's alpha internal consistency reliabilities for PPFKN subscales ranged from 0.85 to 0.94, with total PPFKN at 0.97. The overall mean results of the PPFKN are summarized in Table 3. The overall total score mean for both groups was 3.50 (*SD* = .40) on a 4-point scale, with acute care (*M* = 3.52, *SD* =.42) slightly higher than progressive care (*M* = 3.48, *SD* = .38). Since higher mean scores represent high amounts of construct being measured, an overall mean score of 3.5 represents a high level of patients' perception of feeling known. Overall, 10.6 % of participants scored strongly agree (*M* = 4.00) on all 48 survey items. Highest to lowest subscale mean scores for total score and by level of care were identical with "Experienced Being Recognized as a Unique Human Being" scoring lowest (*M* = 3.32, *SD* = .44) (Table 3). Upon examination of levels of care differences between the two groups (acute and progressive) t- tests results demonstrated no significant differences between any PPFKN subscale scores and overall

Table 3

Mean Scores of PPFKN and JSSR

	Total *M (SD)*	Acute Care *M (SD)*	Progressive Care *M (SD)*	Cronbach's Alpha
PPFKN*	n=123	n=60	n=63	
Total Score	3.50(.40)	3.52(.42)	3.48(.38)	0.97
Felt Safe	3.45(.42)	3.52(.42)	3.48(.42)	0.85
Felt Empowered to Participate in care	3.57(.43)	3.58(.43)	3.56(.43)	0.87
Meaningful Connection	3.60(.41)	3.60(.44)	3.61(.38)	0.94
Unique Human Being	3.32(.44)	3.37(.46)	3.28(.42)	0.89
JSSR**				
Job Enjoyment	54.64(9.14)	51.24(8.89)	56.33(9.27)	
Total Score	4.37(.53)	4.25(.51)	4.49(.54)	
Pay	3.48(.73)	3.51(.70)	3.45(.75)	
Professional Status	4.34(.60)	4.19(.57)	4.49(.62)	
Autonomy	4.26(.45)	4.15(.42)	4.37(.47)	
Decision-Making	3.92(.59)	3.78(.56)	4.06(.62)	
RN-MD Interactions	4.28(.39)	4.36(.36)	4.20(.41)	
RN-RN Interactions	5.11(.39)	4.92(.39)	5.29(.38)	
Tasks	4.15(.54)	3.95(.51)	4.34(.57)	
Nursing Administration	4.01(.58)	4.01(.55)	4.01(.61)	
Nursing Management	4.87(.69)	4.65(.70)	5.08(.67)	
Professional Development Opportunity	4.77(.46)	4.60(.46)	4.93(.46)	
Professional Development Access	4.85(.41)	4.71(.41)	4.99(.41)	

*PPFKN = Patients' Perception of Feeling Known by their Nurses Scale
**JSSR = NDNQI® RN Survey with Job Satisfaction Scale-R

total score. Additionally, to describe the relationship between patients' perception of feeling known and level of care, point biserial correlations were examined with no significant relationship found. See Table 4 for t-test and correlation results.

Table 4

Level of Care Correlations and T-Tests

Variable	Level of Care Correlations	Level of Care T-Test
1. Felt Safe	-.049	.544
2. Felt Empowered to participate in care	-.030	.331
3. Meaningful Connection	.018	-.201
4. Unique Human Being	-.094	1.044
5. Total Score	-.043	.469

* Significant at the .05 level

Next demographic variables were examined to determine associations with PPFKN subscales and overall total scores. A negative, significant correlation was found between the "Felt Safe" subscale and level of education ($r(121) = -.21$, $p<.05$). Participants with higher levels of education felt less safe than participants with lower levels of education. However, upon linear regression evaluation, the education level of participants explained only four percent of the total variance. Other demographic variables, age, gender, marital status, race/ethnicity and days in hospital were not significantly associated with any PPFKN subscales or overall total score. Table 5 presents demographic variables and corresponding correlation values.

Table 5

Demographic Variable Correlations

Variable	Age	Race	Gender	Marital Status	Education Level	Days in Hospital
1. Felt Safe	-.080	.152	-.080	-.077	-.211*	-.095
2. Felt Empowered to participate in care	-.121	.103	-.021	-.092	-.089	-.124
3. Meaningful Connection	.010	.123	-.089	-.026	-.109	-.107
4. Unique Human Being	-.132	.069	-.057	-.150	-.071	-.105
5. Total Score	-.088	.119	-.065	-.093	-.127	-.115

* Significant at the .05 level

3.3. Nurses practice environment

As noted in Table 3, overall mean score for *NDNQI® RN Survey with Job Satisfaction Scale-R* was favorable at 4.37 (*SD* .53) on a 6-point scale. Individual unit mean scores ranged from 4.18 to 4.59 (Table 2) with acute care lower having a lower job satisfaction score (*M* = 4.25, *SD* = .51) than progressive care (*M* = 4.49, *SD* = .54) (Table 3). Nurses reported perceived quality of care as good to excellent (*M* = 3.48, *SD* = .30) on a 4-point scale. Overall nurses felt they were treated with dignity and respect (*M* = 4.34, *SD* = .30), however recognition and thanked for what they do was only adequate (*M* = 3.70, *SD* = .36) based on a 5-point scale.

An aggregated unit level mean score is standardized as a t-score to obtain the overall Job Enjoyment score for each unit. Combined unit level Job Enjoyment scores was 54.64 (*SD* = 9.14) representing a moderate level of job satisfaction. Individual unit Job Enjoyment scores ranged from 49.41 to 59.71 with acute care lower than progressive care at 51.24 versus 56.33. Overall all participating units had moderate levels of job satisfaction (Table 2 and 3).

3.4. Relationship between patients' perceptions and the practice environment

When individual patients were clustered, or nested, within their nursing units, the results of the mixed linear model for the relationship between the patients' perception of feeling known by their nurses and the nurse practice environment was non-significant ($t(4) = -1.085$, $p > .05$). Fitting the model with consideration to level of care, the relationship of the patients' perception of feeling known by their nurses and the nurse practice environment was also non-significant ($t(121) = -.469$, $p > .05$).

4. Discussion

4.1. Patients' perception of feeling known by their nurses

Considering the value the nursing profession places on developing therapeutic patient-centered relationships, this study contributes to the existing body of knowledge focusing on this important aspect of healthcare. This study set out to examine how the nurse practice environment may or may not have an influence on the patients' perception of feeling known. Historically, research has demonstrated that nurse's value knowing their patients and patients' value feeling known by their nurse (Finch, 2004; Henderson, 1997; Jenks, 1993; Kelly, 2013; Mantzorou & Mastrogiannis, 2011; Zolnierek, 2014). When an effective therapeutic relationship develops between a nurse and their patient, a level of connection and trust is established. To date, little research has been completed specifically examining feeling known from the patient perspective in association with the practice environment. This study's findings add to and support an existing knowledge base which demonstrates the value of knowing (Crocker & Scholes, 2009; Morrison & Symes, 2011), the importance of patient-centered care (Marshall, Kitson & Zeitz, 2012; Rathert et al., 2009), and the influence of nurse practice environments (Aiken, Sloane, et al., 2011; Van Bogaert et al., 2014). Continued examination of patients' perceptions during the health care experience is necessary if full development of patient-centered models of care is to occur.

The results of this study demonstrated a high and favorable perception of an overall perception of feeling known by patients at both the acute and progressive levels of care. With the goal to facilitate patient-centered models of care within organizations regardless of what level of care or unit a patient is on, the fact that no significant

difference between the two levels of care was found in this study is positive. Comparing patients' perceptions between two different levels of care from the perspective of feeling known has not been well explored. Perceptions of feeling known are unique to each individual patient, and developing instruments to quantitatively capture more subjective constructs can be difficult. Results broadly measure the overall nurse patient relationship and the perception of feeling known, specifically narrowing the perceptive to each subscale level. Despite the assumption of higher level of care patients being more medically unstable and requiring more intensive task focused needs, nurses in this study are able to connect with patients and establish patient-centered therapeutic relationships. These results support the importance of patient-centered care (Hobbs, 2009; Marshall, 2012), patient participation in their care (Hoglund, 2008; Sahlsten, Larsson, Sjöström, & Plos, 2008, 2009), establishment of meaningful connections (Sahlsten, et al., 2008; Tyrrell, Levack, Ritchie, & Keeling, 2012), and feeling safe (Andersson, Burman, & Skär, 2011; Lasiter & Duffy, 2013). Therefore, these results have potential to support healthcare's ongoing journey to facilitate the health and welling being of patients served and enhance patient satisfaction with the healthcare experience.

4.2. Being recognized as a unique human being

By uncovering the degree in which patients are feeling known, we gain insight into what aspects of the relationship between the patient and their nurse can be improved. With the subscale, "Experienced being recognized as a unique human being," being the lowest scoring, we begin to understand the gaps patients perceive in their relationship with the nurse. Specific questions addressing the more subjective aspects of care, such as feelings and how hospitalization has impacted the life of the patient and their family,

scored low, but no less important from a patients perspective . These results tie in with previous research findings where a majority (63%) of the patients strongly agreed being treated as a unique individual was very important, however only 55% actually experience this type of care (Land & Suhonen, 2009). Additionally, taking the time to communicate with patients around what is important to them while hospitalized and what their goals are for their stay are many times less important for discussion when nurses are tasked focused and time stretched. When practice environments are task-focused and healthcare leaders and regulatory bodies are demanding more and more from bedside nurses, patient-centered relationships are at risk and nurses may neglect the individualization and uniqueness of patients. This individualization and respect for each unique patient may be the difference between a satisfied and a not so satisfied patient. Certainly trust and the ability to provide the safest level of care are potentially jeopardized. Patients who have an open, connected relationship and who feel safe are more likely to develop a relationship with their nurse which enables them to speak up and trust they will be listened to.

4.3. Experiencing a meaningful connection with their nurse

A critical aspect of patients' perception of feeling known is the connection they develop with their nurses. Patient-centered care and the establishment of a meaningful connection with patients are very similar (Finfgeld-Connett, 2008). Patients in this study scored the subscale, "Experienced a meaningful, personal connection with their nurses" the highest among the overall study population and for both levels of care. With an average mean score of 3.6, this suggests a favorable ability of the nurses to develop a connection with their patients. These finding are in contrast with previous research

where nurses were unable to make an emotional connection with patients (Larsson, 2011) and patients perceived "positive connectedness" less frequently in nurses behaviors (Palese, 2011). However, the concept of connectedness is no less important to patients and is often reported as a strong subtheme in a patient-centered relationship (Marshall, 2012).

4.4. Demographic variables in association with patients' perception of feeling known

Most demographic variables in this study, age, race, gender, marital status, and number of days in the hospital, did not demonstrate a statistically significant association with the patients' perception of feeling known, either within the entire sample or when considered by level of care. Patient's level of education did however have a statistically significant negative association with the "feeling safe" subscale of the PPFKN. Patients with lower levels of education have a higher perception of feeling safe, these findings support prior research where patient's with lower educational levels were more likely to agree with statements about safety (Aro, Pietilä, & Vehviläinen-Julkunen, 2012) and have higher perceived support of individuality and decisional control (Land & Suhonen, 2009) . With previous research suggesting patient's age and gender potentially influencing patients' perceptions of care, safety, participation, and levels of trust (Crickmore, 2010; Rathert, Huddleston, & Pak, 2011) findings from this study do not support this since no significant relationships were found.

4.5 Practice environment and patients' perception of feeling known

The nurse practice environment plays a critical role in influencing the level of nurse satisfaction within an organization. Evidence has supported a relationship between patient outcomes, nurse satisfaction, and healthy practice environments (Rathert & May,

2007, Van Bogaert, Meulemans, Clarke, Vermeyen, & Van de Heyning, 2009). From the results of the job satisfaction survey assumptions can be made regarding the influence on patients' perceptions of feeling known. Nurses in the progressive level of care had higher levels of satisfaction than nurses in the acute level of care, with all participating nursing units scoring in the moderate job satisfaction range, with several units close to high satisfaction (Table 2). These higher levels of satisfaction in progressive care may contribute to the nurse's ability to develop effective therapeutic relationships with their patients and influence the patients' perception of feeling known, thus driving up the average mean score of the PPFKN and contributing to the explanation of why there is no difference in level of care from the patients' perspective.

With no difference found between the patients' perception of feeling known by their nurses and level of care, it is not surprising differences were also not found between nurse satisfaction and the patients' perception of feeling known. With overall PPFKN scores very nearly the same in both levels of care (acute care 3.52, progressive care 3.48), it is difficult to determine, whether acute care scores are lower because of lower nurse satisfaction or progressive care scores are higher related to higher nurse satisfaction. Determining relationships between levels and specialties of care and patient outcomes contributes to understanding subcultures within an organization. Other studies have found not only organizational culture but unit and specialty based subcultures do influence nurse and patient outcomes (Jelastopulu et al., 2013; Mallidou et al., 2011; Van Bogaert et al., 2014). Based on this study's methodology, the actual influence of the practice environment is difficult to determine and warrants further study.

4.6. Quality-Caring Model

The findings of this study were consistent with the adapted version of the Quality-Caring Model© where the unique attributes of both the patients and the nurses combined with the patient care environment form the structural component. Thus the moderately high levels of nurse job satisfaction may have contributed to the similar perceptions of feeling known in both levels of care studied. In the process component, the therapeutic, discipline-specific, independent relationship between the patient and the nurse link to create a connected, caring relationship between them. The high mean score results in the "Experienced a meaningful, personal connection with their nurses" subscale support a connected, caring relationship in this study. Through a connected, patient-centered relationship, knowing of the other can occur; creating a sense of security and feeling cared for. Based on the quality of interactions between the nurses and patients, all components of the adapted version of the Quality-Caring Model© lead to an intermediate outcome of patients' perception of feeling known by their nurses. Additionally, the terminal outcome, patients' experience of care received, is influenced by the nurses' perceptions of their practice environment and overall job satisfaction. This is consistent with other literature findings where perceptions of the practice environment and overall job satisfaction were prominent factors influencing patient caring practices (Burtson & Stichler, 2010; Johannessen, Werner, & Steihaug, 2013; Pavlish & Hunt, 2012; Roch, 2014).

5. Study Limitations

Several limitations warrant addressing related to this study. All data were collected from patients who were still in active care prior to discharging. Although all

patients were assured anonymity and no patient identifiers were included, patient fear of confidentiality could have potentially affected survey responses. Additionally, since the principle investigator was a current employee, in a leadership position, this also could potentially have affected survey responses. Almost half of the patient's requested investigator assistance in completing the survey and this direct assistance may potentially have influenced how a patient responded to questions. There was not a significant difference between investigator assisted and self-completion groups were not significant ($t(120) = -.900$, $p > .05$).

In 2009, the PPFKN was created and psychometrically validated by Somerville, however no further published studies, utilizing the PPFKN, have been found in the literature. The initial instrument validation study was on a primarily white, well educated, married, surgical population, so this is the first known study on a more diverse participant sample, although this study's population was also primarily white.

6. Conclusion

As patient-centered care becomes increasingly important to healthcare leaders, consumers, and those providing the care, incorporating caring measures which allow nurses to connect with and really know their patients will continue to be an area of focus. Continuing to evaluate specifically how the practice environment influences patients' perceptions of care through both qualitative and quantitative methodologies is critical to truly begin to understand the effects of different models of care. To date, limited research has explored the relationship between the practice environment and the patients' perception of feeling known. This study did not confirm the practice environment has a positive or negative effect on the perception of feeling known. However, this study helps

to uncover the degree patients are feeling known and what specific elements of this concept could be improved upon. Results of this study begin to make visible the perceptions of patients and provide insight into which behaviors and aspects of a caring relationship promote feeling known and patient-centeredness. As healthcare leaders strive to create patient-centered models of care, studies specifically exploring patients' perceptions foster the evaluation of different care models and aim to specifically preserve the nurse patient relationship and promote feeling known.

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Manuscript #3

Expanding Understanding of the Patients' Perception of Feeling Known: A Validation Study

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To be submitted to International Journal of Nursing Studies

Abstract

Problem Statement: To promote patient-centered care it is important to expand our understanding of the patients' perceptions of feeling safe and cared for, along with how nursing behaviors promote patient connections and patient's involvement in their own care.

Objective: The aim of this portion of a larger study was to determine the content validity of the *Patients' Perception of Feeling Known by Their Nurses Scale*.

Methods: A content validity study conducted in a 536 bed hospital on six patient care units (four progressive and two acute). Patients (N = 110) completed a supplemental survey designed to validate the content of the *Patients' Perception of Feeling Known by their Nurses Scale*. Using content analysis, repetitive codes were allowed to emerge. Codes were consolidated into categories and subcategories.

Results: Results of the content validity survey offered validation to the core contents of the *Patients' Perception of Feeling Known by Their Nurses Scale*. Specifically, findings offered content validation on two subscales: "Experienced a meaningful, personal connection with their nurses" and "Felt empowered by their nurses to participate in their care". For the subscale "Felt safe" a focus on safety measures was revealed as a new category. The fourth subscale "Experienced being recognized as a unique human being" suggests nursing has opportunity for improvement in the more subjective aspects of patient care.

Conclusion: Getting to know patients through connected relationships, valuing each patient uniquely promotes a feeling of safety and improves patient outcomes and their participation in their care. This study provides insight into the perceptions of patients, however further research is needed to continue to expand our understanding of patient-centered models of care and what specifically patients desire from therapeutic relationships.

1. Introduction

1.1. Background

At the core of nursing is human caring, with caring relationships and meaningful connections between the patient and nurse at the essence. As medical technology has advanced over the last several decades, healthcare in many ways has become less personable with the emphasis on caring relationships diminishing. Ethically, nursing has struggled with this shift away from humanistic models of care (Watson & Foster, 2003). More recently however, healthcare is beginning to see movement towards patient-centered models of care with the relational aspects of care and connecting with individual patients considered vital for quality patient care. When care is patient-centered and nurses are able to establish therapeutic relationships with their patients, the level of patient participation in their care and the opportunity to uniquely know the patient is enhanced (Henderson, 1997). When nurses provide care to patients without understanding the patient within the context of their life, conflict in healthcare-related goals can arise, resulting in the patient feeling dissatisfied and unsafe. In addition, without the ability to know the patient as a person, care becomes routine and task-driven, which is then potentially perceived by the patient as impersonal and cold (Tanner, Benner, Chesla, & Gordon, 1993).

1.2. Problem

To enhance the healthcare experience and promote patient-centered care, it is important to explore patients' perceptions of feeling cared for and the interpersonal connections developed with nurses during their healthcare encounter. The development

of a connected relationship between an individual patient and their nurse requires nurses to consider each patient's unique self (Bonis, 2009; Finch, 2004). However, engaging patients regarding the relational aspects of their unique self is many times lacking in task focused, time pressured environments of healthcare. Patient-centered models of care focus on the relationship between the patient and the healthcare professional (Kitson, Marshall, Bassett, & Zeitz, 2013), patient participation and involvement in their care (Bolster & Manias, 2010; Kitson et al., 2013), and individualization of care to meet patient's unique needs (Evans, 1996; Land & Suhonen, 2009). As supported in the literature, perceptions of the care experience by the patient can be very different from the perspective of the nurse (Bolster & Manias, 2010; Coughlin, 2012). Collecting data regarding specific aspects of care and specific behaviors of nurses from the patients' perspective may foster additional understanding of the patients' perspective of feeling known and feeling cared for. There is importance to capturing the perceptions of care from the patient's perspective, so complete understanding of phenomena can occur (Creswell & Plano Clark, 2011).

In healthcare, in order to fully provide patient-centered care, we need to expand our understanding of patients' perceptions of feeling safe and cared for, along with how nursing behaviors promote patient connections and patients' involvement in their own care. Surveying patients with a reliable instrument that provides valid data would be one approach to expanding our understanding of patients' perspectives.

1.3. Exploring patients' perception of feeling known

In 2009, Somerville developed the instrument *Patients' Perception of Feeling Known by their Nurses Scale* (PPFKN) to assess the impact of the healthcare environment on the

patient experience. The subscale items of the PPFKN, 1) experienced being recognized as a unique human being, 2) felt safe, 3) experienced a meaningful, personal connection with their nurses, and 4) felt empowered by their nurses to participate in their care, represent relational, subjective patient perceptions. However, to date only one psychometric study has been published assessing this instrument's ability to produce valid data (Somerville, 2009). Therefore, the collection of additional data through structured open-ended questions was deemed necessary to further the validation of the PPFKN.

2. Review of the Literature

2.1. The art of nursing and knowing the patient

Nursing was described as both an art and a science by Florence Nightingale, with the interaction between nurse and client the art, and the empirical or scientific knowledge of nursing the practice (Nightingale, 1863). Artful nursing practice benefits the patient through enhancement of both physical and emotional well-being. Through the development of a patient-centered relationship, the nurse gains a full understanding of the personal needs of the patient and is able to adapt patient care to meet individual needs of patients (Finfgeld-Connett, 2008). Interacting with patients on a personal and relational level allows the nurse to learn about their patient's experiences, behaviors, feelings and perceptions leading to truly knowing the patient. "Knowing the patient" has been identified as a central theme of previous studies and is an essential element of patient-centered, individualized care (Crocker & Scholes, 2009; Jenks, 1993; Morrison & Symes, 2011).

2.2 Knowing and patient-centered care

The concept of knowing is an integral aspect of nursing practice. To know the patient as a person, and to understand what is brought to the relationship, fosters an openness and trust between the nurse and the patient which is necessary for the relationship to be patient-centered. Knowing can be both personal and aesthetic, with personal knowing the knowing of oneself, and aesthetic knowing the art of nursing (Mantzorou & Mastrogiannis, 2011). However, knowing is more than knowing about the patient, it includes the establishment of a personal relationship and connection with the patient. Personal relationships are needed to facilitate effective clinical decision-making (Jenks, 1993), and contribute to the individualization of care (Evans, 1996). By recognizing patients as unique human beings and fostering meaningful connections, patients' lives are touched in a caring manner and ultimately positive patient outcomes and improved relationships occur.

The concept of knowing the patient has emerged as a central theme in many studies conducted to date. Using focused interviews, field notes, and participant observations, Crocker and Scholes (2009) observed knowing the patient as an essential element of patient-centered, individualized care during mechanical ventilation weaning. Additionally, in a descriptive synthesis of 16 studies on expert nursing practice, five themes were revealed, including knowing the patient (Morrison & Symes, 2011). In an attempt to identify strategies to identify, interrupt, and correct errors, Henneman et al. (2010) asked intensive care nurses to describe strategies used to identify errors. Of the eight themes revealed, knowing the patient was a reoccurring theme important for

identifying errors and ensuring patient safety (Henneman et al., 2010). When nurses know their patients, the uniqueness of each individual patient is understood and the planning of care can be individualized. Not knowing the patient leads to a standardized approach to care and potentially depersonalization of the patient occurs. A standardized approach to care denies patients their dignity and enhances their feelings of insecurity and vulnerability (Whittemore, 2000).

3. Methods

3.1. Design/Research Approach

As background, in a large study Mollon (2015) used quantitative and qualitative descriptive methods to explore patients' perceptions of feeling known during an inpatient hospitalization. Both methods used approaches to data collection that took place concurrently over a three month period of time in six patient care units, two acute care and four progressive care. The aim of the quantitative method approach was to describe the patients' perception of feeling known by their nurses during their inpatient hospitalization, including level of care differences as measured by *Patients' Perception of Feeling Known by Their Nurses Scale* (PPFKN) and those findings are reported elsewhere (Mollon, 2015). The aim of the qualitative method approach to the study was to determine the content validity of the PPFKN and is reported here.

3.1.1. Validation Study

Patient participants received a supplemental survey designed for the content validity study. These were distributed along with each PPFKN survey. The content validity survey included four open-ended questions structured to match each of the four PPFKN subscales. The specific aim of administering the content validity survey was to

offer an opportunity for patients to provide supporting and/or additional information regarding each subscale. Using content analysis as a validation strategy, patient responses to each survey question were analyzed within each subscale topic.

3.2. Conceptual Framework

The Patient's Experience of Care (PEC) conceptual framework was designed to structure both portions of the large study. The PEC was developed from an adapted version of the Quality-Caring Model© (QCM) authored by Duffy and Hoskins' (2003). The QCM is grounded in Donabedian's (1966) structure, process, and outcome model and Watson's (1985) Theory of Human Caring thus creating a mid-range model that is capable of supporting research studies (Duffy, 2009). The structure component of the QCM refers to the composition of individuals, patient and nurse, including unique life experiences and for the nurse, their attitudes and behaviors (Figure 1). Focusing primarily on the therapeutic, discipline-specific, independent relationship between the patient and the nurse is the process component, representing the caring relationship between the nurse and the patient. The third component, the terminal outcome of the patient's experience of care (perception) and the intermediate outcome of feeling known by their nurses is reflected. The intermediate outcome of feeling known by their nurses is dependent on all components of the QCM as represented by the smaller arrows. However, as represented by the larger arrow, attainment of terminal outcomes can be the result of achieving the intermediate outcome of feeling known by their nurses or the intermediate outcome is achieved as a result of achieving the terminal outcome first. For the purpose of this instrument validation portion of the study, the patient responses to the

structured questions (perception) is the outcome of care received and reflects the relationship developed between the patient and the nurse leading to feeling known.

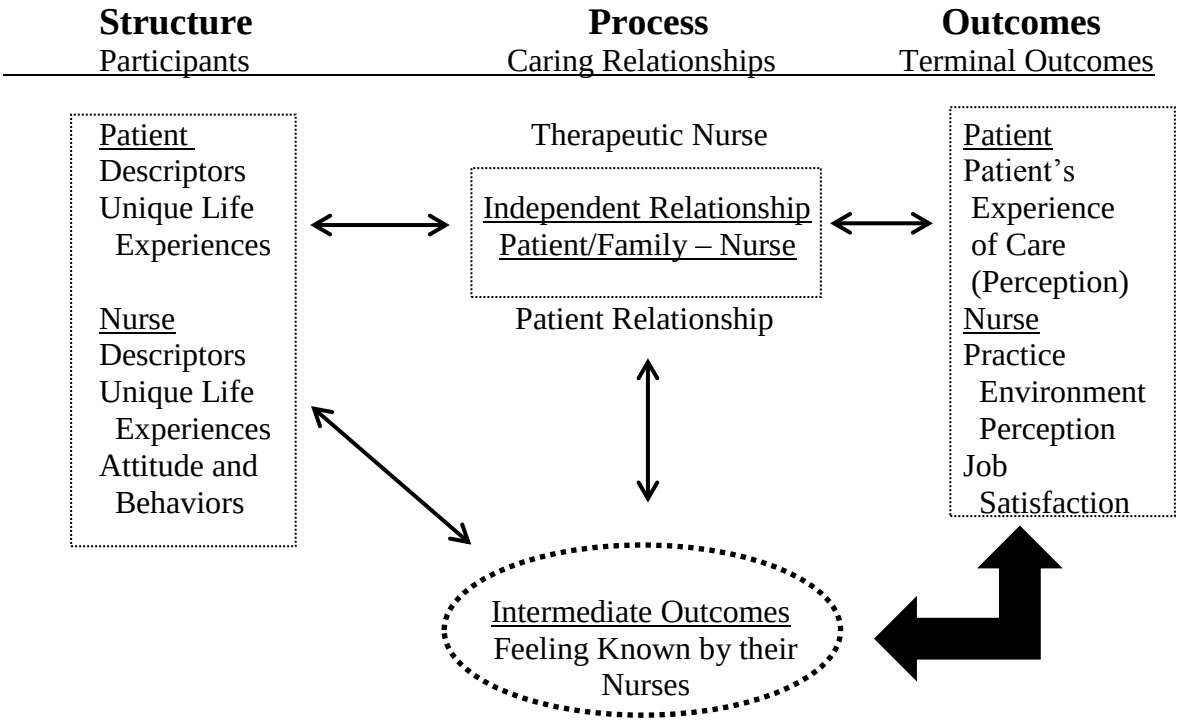

Figure 1: Adapted Quality-Caring Model© (Duffy, 2009)

3.3. Sample

A convenience sample of hospitalized patients from six patient care units (two acute and four progressive) in a not-for-profit ANCC Magnet® designated community hospital with 536 acute care beds were recruited for the large study. Patients who were 18 years of age or older, English speaking, with no change in level of care or nursing care unit, and a hospital admission time of at least 48 hours were eligible to participate. Acute care unit nurses care for four or five non-monitored patients at one time, while progressive care nurses care for not more than four patients whose needs require more intensive monitoring. Both levels of care receive support from nursing assistants and have a patient bed capacity from 33 to 41 patients.

3.4. Demographics and content validity survey

Demographic questions captured age, race, gender, marital status, years of education, and number of days in the hospital. Each patient participating in the study was asked to complete a content validity survey consisting of four structured open-ended questions addressing each of the four PPFKN subscales. Survey questions were developed and guided by existing literature on each of the four PPFKN subscale topics. Readability ease was 75.9 and grade level was 5.3, which was appropriate for the sample based on average educational level (Table 1 and Table 2).

Table 1

Structured Open-ended Questions

Questions	Readability
1. Explain how the staff have made a connection with you during this hospitalization.	
2. What have we done that helped you to feel cared for?	Flesch readability ease = 75.9
3. Describe your feelings of safety during this hospitalization.	Flesch-Kincaid grade level = 5.3
4. Explain how the staff have included you in your care?	

3.5. Procedure

Patients scheduled for discharge on participating nursing care units were screened each day. Patients meeting inclusion criteria were provided the details of the study and were consented. The quantitative survey (PPFKN) was presented to the participant first, followed by the content validity survey. While patients were not instructed to complete

the data collection forms in any particular order, the order of presentation to the patient was always the same by the principle investigator (PI) who was the only data collector. An offer for assistance in completing the study materials was provided to all participants and the order of data collection when PI assisted was always the PPFKN first. To complete both data collection forms took about 20 minutes.

3.6. Content validity survey data analysis

All content validity survey data were collected prior to reviewing any of the study data. These data were analyzed within apriori domains (PPFKN subscale topics). The data were systematically analyzed using principles of content analysis. Data were transcribed verbatim from each survey and reviewed carefully to get a sense of potential codes and themes. Transcribed data was uploaded into Dedoose, a secure qualitative data analysis program (Dedoose, 2015). Using content analysis, repetitive codes for each domain were allowed to emerge. Codes for each response were then reviewed and consolidated into similar themes or categories. Once code consolidation occurred, codes were then further grouped into like themes and given a category name. Each category consisted of two to six codes or subcategories. Once final codes were determined, data was analyzed via Dedoose through review of code frequency and the co-occurrence of two codes together with the same patient response.

As the last step, results from each subscale-specific question on the content validity survey were matched to confirm alignment with the PPFKN items; in other words, validate the content of the PPFKN subscales.

3.7. Ethical considerations

The institutional review board of the participating hospital and the University provided study oversight. Prior to data collection, the details of the study were reviewed with all participants and informed consent was obtained according to human subjects protection requirements.

4. Results

4.1. Sample description

Of the 145 patients approached to participate in this study, 128 returned their study packets, 64 from each level of care. Five patients were eliminated from the quantitative data analysis due to greater than 10% missing data, leaving a total of 123 patients (acute care n= 60 and progressive care n=63). All patients were offered the opportunity for researcher assistance for completing the study material, and 59 (48%) of participants requested this. Not all patients completing the *Patients' Perception of Feeling Known by Their Nurses Scale* (PPFKN) completed the content validity survey, including 13 researcher-assisted patients who were too fatigued to continue after completing the PPFKN. In total, 18 patients did not complete the content validity survey and another 16 left one or more question blank. The final sample size for the content validity survey was 110. Study population was equally distributed between males and females, had a mean age of 60 years, predominately married and white, and with a mean education level of 14 years (Table 2).

Table 2

Characteristics of Patient Study Participants

Demographics Factors	Total % (n=123)	Acute Care % (n=60)	Progressive Care % (n=63)
Age			
Mean (Years)	60.4	58.2	62.4
25-40	8.1 (10)	10.0 (6)	6.3 (4)
41-50	15.4 (19)	16.7 (10)	14.3 (9)
51-60	25.2 (31)	30.0 (18)	20.6 (13)
61-70	23.6 (29)	20.0 (12)	27.0 (17)
71-80	18.7 (23)	20.0 (12)	17.5 (11)
81-90	8.9 (11)	3.3 (2)	14.3 (9)
Race			
White	70.7 (87)	71.7 (43)	69.8 (44)
Black	5.7 (7)	3.3 (2)	7.9 (5)
Hispanic	9.8 (12)	8.3 (5)	11.1 (7)
Other	13.8 (17)	16.7 (10)	11.1 (7)
Gender			
Female	50.4 (62)	56.7 (334)	44.4 (28)
Male	49.6 (61)	43.33(26)	55.6 (35)
Marital Status			
Single	20.3 (25)	18.3 (11)	22.2 (14)
Divorced	23.6 (29)	26.7 (16)	20.6 (13)
Widowed	10.6 (14)	8.3 (5)	12.7 (8)
Married/Living with Partner	42.3 (52)	45.0 (27)	39.7 (25)
Separated	3.3 (4)	1.7 (1)	4.8 (3)
Education			
Mean (Years)	14.0	14.7	13.4
No Diploma	5.7 (7)	5.0 (3)	6.3 (4)
High School Grad	32.5 (40)	28.3 (17)	37.5 (23)
Some College	37.4 (46)	31.7 (19)	42.9 (27)
College Grad	11.4 (14)	16.7 (10)	6.3 (4)
Post Grad	10.6 (13)	15.0 (9)	6.3 (4)
Missing	2.4 (3)	3.3 (2)	1.6 (1)

4.2. Content validity survey findings

After thoroughly reviewing and coding all open-ended question responses, distinct categories and subcategories emerged for each survey question. Each question and its corresponding categories will be reviewed separately. See Table 3 for all revealed categories and subcategories related to each content validity survey question.

4.2.1. Experienced a meaningful, personal connection with their nurses

The first question, "Explain how the staff have made a connection with you during this hospitalization?" had two main categories: Caring and building a relationship. The category caring had the subcategories of feeling cared for, comfort, concern, and meeting needs. In the category building a relationship the subcategories of got to know me, personable, talking and sharing themselves, friendly and kind, and understanding were present. Overall patients reported feeling connected with their nurses' as reflected in statements such as "*Talking to me about my family and their family and we connected*" and "*There were kind, personal connections with each of them.*" Patients gave examples of different ways they connected with their nurses as reflected in these statements, "*We talked about things we had in common, careers, kids, grandkids, pets, family*" and "*Shared themselves with me. I have learned about each one of them.*" Some patients found connection to be more related to the caring aspects of the relationship. Statements such as "*Took care of me right away, met my needs, and gave special care*" and "*Excellent treatment all around, staff, cafeteria, nurses, doctors, they were all friendly and concerned about me and made me feel better and met all my needs and comfort*" reflected the caring aspects of the connection.

Table 3

Structured Open-Ended Questions and Revealed Categories and Subcategories

Question 1	Categories and Subcategories	Question 3	Categories and Subcategories
Explain how the staff have made a connection with you during this hospitalization?	Building a Relationship Got to Know Me Personable Talking and Sharing Themselves Friendly and Kind Understanding Caring Feel Cared For Comfort Concern Meeting Needs	Describe your feelings of safety during this hospitalization.	Safety Measures Presence Checked on Me Care Assistance Overall Feeling of Safety Felt Safe Secure
Question 2	**Categories and Subcategories**	**Question 4**	**Categories and Subcategories**
What have we done that helped you to feel cared for?	Providing Care Needs Met Help Provided Treatment Monitoring Care Comfort Interaction Attention Listening Kind and Friendly Talking Connection Exchanging Information Informing Inquiring	Explain how the staff have included you in your care.	Inclusion Participate in decisions Including Information Answering Questions Asking Questions Informing Explaining Caring Feelings Talking

Some subcategories were noted to occur in conjunction, or co-occurring, with each other more than others. Another words, a patient response reflected the same two

subcategories within their response more frequently than other subcategories. Co-occurrences between the categories of "got to know me and talking and sharing themselves", "comfort and meeting needs", and "friendly and caring" were the most frequently occurring co-occurrences within patient responses to the question "Explain how the staff have made a connection with you during this hospitalization?" These common co-occurrences are reflected in the statements "*Very kind and friendly. Seemed to care about me as an individual*" and "*Talking about my personal life (professional career, family and goals) as well sharing about their own.*" The majority of patients provided positive statements regarding the caring connection the nurses' built with them; however a few responses were not as positive. One patient went so far as saying "*Have not seen any examples of a connection.*"

4.2.2. Experienced being recognized as a unique human being

The second question "What have we done that helped you to feel cared for?" is intended to explore the actions and behaviors of nurses and determine whether they are practicing from a caring base. This question ties to the subscale "experienced being recognized as a unique human being." Three main categories were revealed from this question, including providing care, interaction, and exchanging information. Subcategories under providing care included needs met, help provided, treatment, monitoring, care, and comfort. For the category interaction, subcategories were attention, listening, kind and friendly, talking, and connection. The third category exchanging information encompassed informing and inquiring. Overall most patient statements reflected the provision of care; however the connection developed with patients in the process of providing care was also reflected. Provision of care statements included

"*Medications on time. Met my needs when I needed something. Helped me to go for a walk*" and *"The staff was very attentive to my needs. They made sure I was always warm enough or cool enough. They refreshed my bed linens, my gowns and made me feel comfortable."* The statement, "*They showed concern for my pain level, made me laugh during a hard time, and help me with my recovery*" reflects both providing of care and patient interaction. A few patients equated the exchange of information as helping them to feel cared for, statements like "*Providing frequent updates on status and medication for appropriate symptoms*" and "*Explained what they were doing, what medications they were giving*" were given. By far, most statements reflected some form of providing care and meeting needs as important in feeling cared for. One patient summed it up well in the statement, "*Bad day or good they are right there, physically supportive, helping me sit down, get up, telling me I can do it*."

4.2.3. Felt safe

Question number three "Describe your feelings of safety during this hospitalization?" was created to explore the concept feeling safe from the patients' perspective. Two categories represent this question, safety measures and overall feelings of safety. For this question patient's had difficulty separating just feeling overall safe and what specifically contributes to feelings of safety. Subcategories of safety measures included presence, checked on me, care, and assistance, while subcategories for overall feeling of safety included felt safe and secure. Multiple patients (50%) used statement such as "*Excellent, I felt really safe*", "*Felt very safe*", and "*Felt completely safe*" in their description of feelings of safety. Many patients also gave reasons why they felt safe, "*I felt very safe because the staffs always there when I need them. They even insist to help even when I do not need help at the moment*" and "*Their attitude made me feel safe."*

Patients referred to the use of safety measures as a large factor in feelings of safety. Safety measures could be physical measures as reflect by this patient "*I'm totally safe. Alarm on my bed. Told me to call them if I needed anything. Nonskid slippers, stand by assist with gait belt*" or nurse monitoring behaviors, "*I felt safe at all times as there were regular and frequent visits to my room by nurses*." No patients expressed feeling unsafe during their hospitalization.

Many patients tied the subcategory of felt safe with a few consistent subcategories, including safety measures, care, and presence. Caring and presence in conjunction with felt safe are noted in the following statements, "*I felt extremely safe and well cared for*", "*I feel safe because I know the staff are right here real close*" and "*Here I felt safe because someone was near*." Safety measures and feeling safe was evident in many statements such as this "*Gave me a walker, turned on the lights. Very cautious with personal safety. Watching for dizziness*."

4.2.4. Felt empowered by their nurses to participate in their care

The final question "Explain how the staff have included you in your care?" directly corresponds to patient-centered care. Main categories for this question are information, inclusion, and caring. Subcategories for information include answering questions, asking questions, informing, and explaining, for inclusion they are participating in decisions and including, and for caring, feelings, and talking. Receiving and providing information in the form of questions or inquiry was exhibited in many patient responses, as reflected in these statements, "*The staff explained to me about my treatment. They asked me about my medications, when I took it*" and "*The nurses will ask me what I want and then they would explain everything and then do what I want. They*

would explain what I needed to know." Patients expressed receiving explanations about care as an important aspect of feeling included in care, as demonstrated in the following statements, "*Always explained the options and allowed me to discuss my feelings and be a partner in the decision making process*" and "*By explaining what they were doing and asked me questions to ensure that I understood what was being done to me*." The inclusion subcategory is at the heart of participating in care. Statements such as "*They included me in all aspects of my care*", "*Try to include me in everything. Ask what I want and do not want*", and "*Like I was part of the team they respect my opinion*" all reflect inclusion and patient-centered care behaviors and actions. In the subcategory caring, as with all previous questions, the concept of caring was expressed as important to patients in relationship to feeling included in their care. One patient expressed her feelings this way, "*They made me feel like they care for me it is not because it is their jobs, but it is because they care about me*."

Upon further analysis, several subcategories of the question "Explain how the staff have included you in your care," were found to occur in conjunction with each other. The subcategory feelings appeared in co-occurrence with both caring and asking questions. Nurses were able to address patients' feelings as well as attending to questions smoothly as supported by these statements, "*Asking me about how I was feeling and if I had any questions, being here for me*" and "*They constantly asked what I needed, how I was feeling and really seemed to listened*." As would be expected, the co-occurrence of participating in decisions was noted in conjunction with both included me and explaining. These co-occurrences are demonstrated by these patient statements, "*They tell me what medications I'm getting. Helped me decide if there is something I need to do or not to do.*

Everyone likes to know what's going on" and "*The nurses will ask me what I want and then they would explain everything and then do what I want*."

4.2.5. PPFKN items and content validity survey data combined

Once all the categories and subcategories were determined for each content validity survey question, they were compared with the *Patients' Perception of Feeling Known by their Nurses Scale* (PPFKN) items under each subscale for confirmation and validation of similarities. Each question and subscale was analyzed separately. Under the subscale, "Experienced a meaningful, personal connection with their nurses" there are 17 items, and when aligned with the two categories and nine subcategories, all but one of the items corresponds and is supported. The item, "My nurses made me feel special" did not fit well under any of the categories or subcategories. For the subscale, "Experienced being recognized as a unique human being" alignment was less well defined. When the three categories and 13 subcategories were aligned with the 15 items under this subscale, only six corresponded. The subscale "Felt safe" has eight items and only half of the items corresponded with the two categories and six subcategories. The final subscale, "Felt empowered by their nurses to participate in their care" has eight items, and the three categories and eight subcategories corresponded to all but one of the items. The item "I did not feel rushed by my nurses" did not align well to any of the categories or subcategories.

5. Discussion

The two portions of this study (Mollon, 2015 presents portion one), using two parallel methodologies, is one of few studies exploring the phenomena feeling known from the patients' perspective. Knowing in nursing practice is not a new phenomenon

and has been demonstrated in many studies to be important and valued (Crocker & Scholes, 2009; Henderson, 1997; Jenks, 1993; Morrison & Symes, 2011). Obtaining the patients' perspective regarding their healthcare experience is a healthcare priority and a key component of patient-centered care. The findings from this study offer both validation support and new perspectives regarding the patients' perception of feeling known.

Data analysis suggests an alignment between many of items in the *Patients' Perception of Feeling Known by their Nurses Scale* (PPFKN) and the revealed categories and subcategories from the content validity survey. Advancing knowledge on more subjective concepts can be difficult and open to disparate findings study to study. This study's findings are relevant to organizations focusing on improving the patient care experience and advancing patient-centered models of care. Each subscale of the PPFKN will be discussed separately since content analysis was completed based on data received under each individual structured open-ended question.

5.1. Experienced a meaningful, personal connection with their nurses

The subscale, "Experienced a meaningful, personal connection with their nurses" was the highest scoring of the four PPFKN subscales (Table 4). The degree in which nurses connect with patients has been associated with the level of satisfaction patients feel (Palese, 2011), patients willingness to participate in care (Tyrrell, William, Ritchie, & Keeling, 2012), and quality of care (Marshall, Kitson, & Zeitz, 2012). The main

Table 4

PPFKN Subscale Mean Scores

	Total *M (SD)*	Acute Care *M (SD)*	Progressive Care *M (SD)*	Cronbach's Alpha
PPFKN	n=123	n=60	n=63	
Total Score	3.50(.40)	3.52(.42)	3.48(.38)	0.97
Felt Safe	3.45(.42)	3.52(.42)	3.48(.42)	0.85
Felt Empowered to Participate in care	3.57(.43)	3.58(.43)	3.56(.43)	0.87
Meaningful Connection	3.60(.41)	3.60(.44)	3.61(.38)	0.94
Unique Human Being	3.32(.44)	3.37(.46)	3.28(.42)	0.89

Results from Portion One of Study (Mollon, 2015)

categories of "building a relationship" and "caring" suggest patients find connecting with the nurse not just about the relationship but about feeling cared for. The experience of feeling cared for supports a concept analysis on connectedness which found caring, as one of seven attributes, and defined caring as experiencing warmth and affection from others and concern for the well-being of others (Phillips-Salimi, Haase, & Kooken, 2012). Subcategory "talking and sharing themselves" defines the nurses' ability to engage with patients and effectively change the relationship dynamics from dependency to mutuality. Through mutuality, the relationship can move from simply providing care to a connectedness between human beings which includes the sharing of experiences and pieces of themselves. Holopaninen, Kasen, and Nystrom (2014) found for a caring encounter to actualize, the prerequisites of presence, recognition, availability, and mutuality must occur. This refocusing on the relational dynamics of the nurse patient relationship is dependent on transforming patterns of communication and authenticity so true presence and connectedness between human beings can occur (Watson & Foster,

2003). This connectedness it at the heart of patient-centered care and is key to a patient's perception of feeling known.

Patients' responses in regards to how nurses made a connection with them demonstrated high agreeability with existing items on the *Patients' Perception of Feeling Known by their Nurses Scale* (PPFKN). The mean score on the PPFKN for this subscale was the highest scoring of the four subscales and suggested patients in this study had a meaningful connection with their nurses. This was further supported by the close alignment of the revealed categories and subcategories from question one and the 17 items within this PPFKN subscale. Every category and subcategory was supported by at least one item with the exception of subcategory "got to know me." However, this subcategory is closely related to most of the other subcategories in the "building a relationship" category and could be absorbed into existing subcategories. Overall, patient responses offer validation to the existing items on the PPFKN for connection.

5.2. Experienced being recognized as a unique human being

This subscale, "Experienced being recognized as a unique human being." was the lowest scoring of the four subscales on the PPFKN (Table 4). By addressing the more subjective aspects of care, like feelings and the impact of hospitalization on patients' lives, we begin to gain insight into the context in which patients enter the nurse patient relationship. Behaviors and attitudes contributing to patients' feeling cared for, tie directly back to the relational aspects of the relationship and the connections established from the beginning. Nurses who practice from a caring base respect human beings through unconditional acceptance and appreciate the unique meanings patients bring (Duffy, 2009). During the provision of care, the uniqueness of each patient is revealed

and allows the nurse opportunity to provide care with consideration to a patient's individual values and preferences. By inquiring about the patient's life outside of the hospital, the impact and experience regarding hospitalization and what specifically is important to the patient, the nurse is able to acquire insight into the history and experiences of the patient, creating opportunity to accept the patient as unique (Radwin & Alster, 2002; Somerville, 2009). The goal of exploring what specific elements patients contribute to feeling cared for was addressed in the second open-ended survey question (Table 1). Although patients primarily referred to the provision of care, many patients discussed the interactional elements of listening, talking, and connecting. These findings support the adapted QCM (Figure 1), where through interaction and connection, the patient feels cared for and knowing occurs (Duffy, 2009).

Many of the items on the PPFKN for the subscale, "Experienced being recognized as a unique human being" were not directly aligned with the subcategories revealed for question two (Table 1 and Table 3). With only six of the 15 items directly aligned, it has to be considered whether this open-ended question truly captured the essence of experienced being recognized as a unique human being. Research is clear regarding the importance of feeling cared for and the relationship to positive health outcomes (Andersson, Burman, & Skär, 2011; Duffy, 2009; Marshall et al., 2012) The items within the PPFKN subscale, "Experienced being recognized as a unique human being," captures the more subjective aspects of nursing care, whereas inquiring what has helped you to feel cared for may not. At the heart of this subscale is knowing the patient through an understanding of the patient's behaviors, experiences, feelings, and perceptions. To accomplish this, nurses must take the time to ask questions outside of small talk and

patient care related topics. Since many of the relational items in this subscale were the lowest scoring items on the PPFKN (Mollon, 2015), for patient-centered care to happen, nurses must not only practice from a caring base they must explore the individuality of each patient within their care. Results from this study suggest nursing has opportunity for improvement toward recognizing patients as unique human beings.

5.3. Felt safe

Overwhelmingly patients in this study reported feeling safe. Research has consistently found feeling safe to be an overarching need for patients during inpatient hospitalizations (Aro, Pietilä, & Vehviläinen-Julkunen, 2012; Hupcey, 2000; Lasiter, 2011). For patients, to feel safe may be much different than being safe. However, as people work at all levels of health care to improve the safety and quality of care, is it really known what it means to the patient to feel safe? The goal of question three (Table 1) was to explore patients feelings of safety during their hospital stay. Feeling safe has been defined as a sense of security and freedom from harm derived from the perception of the care experience (Mollon, 2014). Feeling safe has different meaning for each individual patient, with patients reporting feeling cared for, trust, knowing, and being informed as elements of feeling safe (Aro et al., 2012; Hupcey, 2000). In this study many patients primarily reported "feeling safe" but did not provide detailed descriptions of their feelings. While it is positive that patients felt safe, obtaining additional details regarding this phenomenon was not consistently provided. The categories of safety measures and an overall feeling of safety and their subsequent subcategories, align with previous research findings where patient expressed frequent checking, timely assistance, presence and proximity, and development of a good nurse patient relationship as important to feeling safe (Andersson et al., 2011; Lasiter, 2011).

Patients in this study did not seem to equate the information sharing between healthcare providers (doctors, nurses) as contributing to their safety during hospitalization. The three PPFKN items related to information sharing in the feeling safe subscale were not validated in the content validity survey analysis. However, patients did speak of specific safety measures they felt contributed to feeling safe and the PPFKN subscale items do not specifically address safety measures. Overall, the categories and subcategories revealed from question three (Table 1) supports most of the items within the subscale felt safe, with only a focus on safety measures revealed as a new category. Healthcare providers communicating and collaborating in the presence of the patient and linking for the patient the importance of this collaboration to safe patient care, may improve patients understanding of all elements of safety.

5.4. Felt empowered by their nurses to participate in their care

This final subscale, "Felt empowered by their nurses to participate in their care," is the core of patient-centered care and potentially is a consequence to all the other previously discussed subscales. Before patients are able to participate in their care, basic care needs and feelings of safety and security must be met. Patient participation has been defined and conceptualized to include establishing a trusted, mutually respective, and connected relationship, sharing of information and knowledge, mutual engagement and surrendering of power and control (Sahlsten, Larsson, Sjöström, & Plos, 2008). In this study, patients related "inclusion", "information", and "caring" as the main categories important in participating in their care. The need for knowledge or information (Eldh, Ekman, & Ehnfors, 2010; Larsson, Sahlsten, Segesten, & Plos, 2011), an emotionally connected relationship (Larsson et al., 2011), and preferences towards decision making

(Florin, Ehrenberg, & Ehnfors, 2008) are all elements potentially influencing the degree of patient participation.

The eight items on the PPFKN under the "Felt empowered by their nurses to participate in their care" subscale aligned nicely with the categories and subcategories revealed from the patient responses to question four (Table 1). The item, I did not feel rushed by my nurses, did not directly align with any subcategories revealed, however it can be assumed if patients feel rushed or sense impatience on the part of the nurse, the degree of participation will be diminished. The elements of this subscale of the PPFKN are validated based on the analysis of question four.

5.5. Limitations and recommendations

Based on this review and comparison of the two portions of this study, some unique features and limitations are worthy of discussion. During the evaluation and coding of the content validity survey data, similarities were noted related to the wording of the *Patients' Perception of Feeling Known by their Nurses Scale* (PPFKN) items and the words used by patients to answer the questions. Although patients were not given specific instruction to complete one data collection form before the other, the order of presentation to the patient by the PI was the same every time and it is assumed that most participants completed the PPFKN survey prior to the content validity survey. Based on this assumption, one cannot determine the level of influence the completion of the PPFKN survey had on patient responses on the content validity survey. Reflecting on the close alignment and degree of confirmation between the PPFKN subscale items and the categories and subcategories revealed from the content validity survey, it can be assumed there was some degree of affect. Additionally, since 48% of the patients requested PI

assistance in completion of the data collection forms, and the PI was a current employee in a leadership position, this could have also influenced the responses received, especially to the content validity survey. To eliminate question around the influence from the PPFKN survey to the content validity survey, repeating data collection solely using the content validity survey independently might produce additional clarity around the key components of this study and ultimately the phenomena of feeling known from the patients' perspective.

The patient responses to the structured open-ended questions on the content validity survey many times were either overlapping or in some cases almost identical. In addition, many of the categories and subcategories revealed for each question were either very similar or identical. For example, the concept of care or caring was included as either a category or a subcategory for each of the four questions. The approach in this study was to analyze each question separately, determining categories and subcategories for each question. To obtain additional clarity around the concepts of this study, a second approach, looking at all the data without consideration of the subscales or individual questions, to see what might appear is worthy of consideration. It would be recommended for this second approach to be completed by one or two researchers not currently associated with the data or results of the study to obtain non-biased conclusions.

6. Conclusion

The goal of this validation study was to expand understanding of the patients' perception of feeling known by their nurses during an inpatient hospitalization. Using a content analysis approach, responses to structured open-ended questions were analyzed to determine alignment with the subscales of the instrument *Patients' Perception of Feeling*

Known by their Nurses Scale (PPFKN). Although the results of the content validity survey offered validation of the core contents of the PPFKN, the more subjective aspects of patient care continue to be less visible to patients. If nursing is to truly know their patients, then we must move beyond the technical, medical focused aspects of care and provide care from a caring base which is patient-centered. Getting to know patients through connected relationships, valuing each patient uniquely promotes a feeling of safety and improves patient outcomes and their participation in their care. This study provides insight into the perceptions of patients, however further research is needed to continue to expand our understanding of patient-centered models of care and what specifically patients desire from therapeutic relationships.

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Appendix A USD IRB

University of San Diego

ENTERED 8/15/14

Institutional Review Board
Project Action Summary

Action Date: August 14, 2014 *Note: Approval expires one year after this date.*

Type: __New Full Review ___New Expedited Review ___Continuation Review _X__Exempt Review
____Modification

Action: _X__Approved ___Approved Pending Modification ___Not Approved

Project Number: 2014-08-309
Researcher(s): Deene L. Mollon Doc SON
Dr. Linda Urden Fac SON
Project Title: Patient's Perception of Feeling Known by their Nurses and the Nurse Practice Environment

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@sandiego.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.

Deené L. Mollon — Hahn School of Nursing, May 19, 2014
Researcher (signature) — Department/School and Date

Deene Mollon — dmollon@sandiego.edu — 619-917-2795
Researcher (printed) — REQUIRED: email — Phone

Linda Urden — Nursing — 5-19-14
Faculty Advisor (signature) — Department/School and Date
(Only required if PI is a **USD Student**.)

Dr. Linda Urden — urden@sandiego.edu — 619-260-7608
Faculty Advisor name (printed) — REQUIRED: email — Phone

N/A
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).

N/A
USD Sponsor name (printed) — Department/School and Date

See attached.
School/College IRB 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.)

See attached.
Dean or His/Her Representative (signature) — Date

APPLICANT: THE FOLLOWING WILL BE SIGNED AFTER YOU SUBMIT YOUR APPLICATION TO THE PROVOST'S OFFICE.

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

Dr. Thomas R. Hunter — 8/14/14
Chair or Administrator to IRB (signature) — Date

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.

See attached. | **Nursing**
Researcher (signature) | Department/School and Date

Deene L. Mallon | dmallon@sandiego.edu 619-917-2995
Researcher (printed) | REQUIRED: email Phone

See attached. |
Faculty Advisor (signature) | Department/School and Date
(Only required if PI is a **USD Student**.)

Dr. Linda Urden
Faculty Advisor name (printed) | REQUIRED: email Phone

N/A |
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).

N/A |
USD Sponsor name (printed) | Department/School and Date

Jane M. Georges | 8/12/14
School/College IRB 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.

Dallas Bross Hardin | 8/12/14
Dean or His/Her Representative (signature) | Date

APPLICANT: THE FOLLOWING WILL BE SIGNED AFTER YOU SUBMIT YOUR APPLICATION TO THE PROVOST'S OFFICE.

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

Dr. Thomas R. Hunter | 8/14/14
Chair or Administrator to IRB (signature) | Date

Appendix B: Permission to Use *Patients' Perception of Feeling Known by Their Nurses Scale*

Subject: Re: Patients' Perceptions of Feeling Known by their Nurses Scale Tools- from Brigham and Women's Hospital in Boston/Jackie Somerville

From: Deene Mollon (mollon@sbcglobal.net)

To: RCANNISTRARO@PARTNERS.ORG;

Date: Wednesday, January 23, 2013 6:26 PM

Thank you so much for the tool. No worries on the delay.

Deene

Sent from my iPad

On Jan 23, 2013, at 1:58 PM, "Cannistraro, Rosemarie" <RCANNISTRARO@PARTNERS.ORG> wrote:

> Dear Mrs. Mollon:
>
> Sincere apologies for my delayed reply, I fear I may have missed seeing this back when you originally sent it. Attached below are the tools you requested online from Jackie Somerville at Brigham and Women's Hospital in Boston. Please feel free to be in touch if you need anything else.
>
> Many thanks for your interest.
>
> Sincerely,
>
> **Rose Cannistraro**
> Executive Assistant to
> ***Jackie Somerville, RN, PhD***
> Chief Nursing Officer and Senior Vice President of Patient Care Services
> Brigham and Women's Hospital
> 75 Francis Street, PB4, Rm 444/Boston, MA 02115
> Ph: 617-732-5858 Cell: 617-416-8153 Fax: 617-732-5343
> Email: rcannistraro@partners.org
>
> Please consider the environment before printing this email. Thank you!
>
>

Appendix C: Permission to Use NDNQI® Satisfaction Data (ANA)

Subject: FW: Use of RN satisfaction survey data (from Deene Mollon via NursingQuality.org)
From: Deene Mollon (Deene.Mollon@sharp.com)
To: mollon@sbcglobal.net;
Date: Tuesday, February 18, 2014 6:14 PM

For school
-----Original Message-----
From: Beth Spornitz [mailto:espornitz@kumc.edu] On Behalf Of NDNQI
Sent: Tuesday, February 18, 2014 11:23 AM
To: Deene Mollon
Subject: FW: Use of RN satisfaction survey data (from Deene Mollon via NursingQuality.org)

Hello Deene,

If your hospital allows it, you are allowed to use only your hospital's data. You cannot use the comparison data, mean, median, etc, but using your own hospital's data is fine.

Beth Spornitz
NDNQI Hospital Liaison
NDNQI@kumc.edu
913-588-1691

"Transforming Nursing into Quality Care"

-----Original Message-----
From: Toks Oriola [mailto:toks.oriola@ana.org]
Sent: Tuesday, February 18, 2014 8:47 AM
To: deene.mollon@sharp.com
Cc: NDNQI
Subject: RE: Use of RN satisfaction survey data (from Deene Mollon via NursingQuality.org)

Hi Deene-

I have included in this e-mail distribution our nurse liaisons who address all operational questions about NDNQI for our hospitals. Ensure you update your e-mail notification address to NDNQI@kumc.edu.

Thanks,

Toks Oriola
Sales and Marketing Specialist
American Nurses Association

National Database of Nursing Quality Indicators® (NDNQI®)
8515 Georgia Ave.
Silver Spring, MD. 20910
P. 301-628-5063
C. 240-893-0806
toks.oriola@ana.org
www.NursingQuality.org

-----Original Message-----
From: Michael Grove [mailto:michael.grove@ana.org]
Sent: Saturday, February 15, 2014 7:25 PM
To: Michael Grove; Toks Oriola
Subject: Use of RN satisfaction survey data (from Deene Mollon via NursingQuality.org)

Deene Mollon says:

I am a current PhD student and I would like to use our hospital's 2014 NDNQI RN Satisfaction Survey data in my dissertation work. Do I need authorization from ANA to use our data in a research study and potentially publish the results of this study.

Thank you for your time

Deene Mollon
Director Acute Care
Sharp Grossmont Hospital
PhD Student University of San Diego

NDNQI-Participating Hospital? Yes

Reply to Deene Mollon at deene.mollon@sharp.com

This message was automatically generated from NursingQuality.org.
Please do not reply directly.