AZUSA PACIFIC UNIVERSITY

# ADULT PATIENT PERCEPTIONS OF NURSE LISTENING BEHAVIORS IN AN ACUTE CARE SETTING

by

Nancy E. Loos

A dissertation submitted to the

School of Nursing

in partial fulfillment of the requirements

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## DEDICATION

This dissertation is dedicated to professional registered nurses wherever they may practice. It is they who, by listening, offer themselves as a therapeutic presence to their patients, making connections, caring, and protecting. They are the difference-makers.

I dedicate this entire journey to the nurse leaders who made me believe I could accomplish this: Dr. Suzanne Robertson, whose vulnerable populations class at California State University, Fullerton, changed my thinking in fundamental ways, predicted this path before I had even completed my master's degree. Her belief in me started me thinking a doctorate was even a possibility. Dr. Rhonda R. Foster, who debriefed with nursing leadership after a Magnet consultation, predicted that several of us would, in fact, continue our education. I felt that she was talking directly to me. Dr. Ann Dechairo-Marino, my colleague and boss at Northridge Hospital Medical Center, introduced me to a very intentional commitment to professional practice, not just by talking about it, but by living it every day; she was the embodiment of professional nursing. She was also the one whose commitment to professional practice caused me to reconnect with my great friend and mentor, the wind beneath my wings, Dr. Maria O'Rourke, whose brilliance, presence, reputation, concern, and mentorship both inspired and propelled me to embrace my professional role and fulfill my academic destiny. She gave me the words to the song I had only been humming. To these outstanding nurses, I humbly offer my deepest gratitude for being in my life. You have all given me a gift that

not only changed me, but I hope will, in turn, change others as they embrace the results of this research.

## ACKNOWLEDGMENTS

So many people deserve to be acknowledged for their love, support, encouragement, clarity, dedication, and wisdom, and they will be. But first, I want to acknowledge the source of all good things: my Lord and Savior, Jesus Christ. Without Him, I could accomplish nothing. He has been my source of joy my entire life and has called me to listen and follow Him. I pray I have done and continue to do that.

A great deal of thanks must be given to Dr. Vivien Dee, my chair, for her boundless wisdom, excellent advice, quick responses, and shared passion for my topic. She gives 100% of herself, 100% of the time. She is tireless. Thank you, Dr. Dee, for supporting professionalism and advocating for all of us in all things. Your support for the theory conference and having us attend the American Academy of Nursing are just two examples of how you put your beliefs into action.

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To Dr. Cone, one of my committee members, who was so encouraging and took the time to ensure the details were right—I am so appreciative of your collegiality and knowledge. And Dr. Ruccione, whose interest in and support of this research made her a

definite must as a committee member, maintained interest in my progress even as she was out on an extended leave during the end of my journey. A huge thank-you is owed to you for who you are and what you added to this dissertation. My last academic-focused acknowledgment goes to Dr. Christina Sieloff, whose extensive knowledge of Imogene King's theories and models helped me see how they best fit with my phenomenon of interest. Christina, your input was invaluable.

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And finally, to my cohort, Diane, Khaled, Maribel, Saleh, Jessica, and Mohammed: could I have done this without you? Probably, yes. Would I have wanted to? The answer is a resounding NO. I have loved learning alongside you and am a better person because of your humanity and unquenchable thirst for knowledge. I will miss our wonderful discussions and weekly check-ins. Now it's your turn!

ABSTRACT

**ADULT PATIENT PERCEPTIONS OF NURSE LISTENING BEHAVIORS IN AN ACUTE CARE SETTING**

Nancy E. Loos
Doctor of Philosophy in Nursing, 2019
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Advisor: Vivien Dee, Ph.D., RN

Good listening is fundamental to effective nursing practice, critical to a healthcare professional's competence, and essential for patient satisfaction and experience. Because nurse listening has been linked to an enhanced patient experience and improved patient outcomes, it has been considered important enough that the U.S. Centers for Medicare or Medicaid Services have solicited patient perception as part of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (CMS, n.d.). However, little can be found in the literature that describes which nursing behaviors are perceived by patients as listening behaviors. Via face-to-face interviews, this study sought to discover, describe, and interpret the perceptions of recently hospitalized adult patients on their nurses' listening behaviors in an acute care setting, and to identify which behaviors caused them to believe listening had occurred. Perceptions of the reverse experience (the experience of not being listened to and its associated behaviors) was also elicited, as were related outcomes for both. This qualitative study used as a framework

King's Theory of Goal Attainment (KTGA), a middle range theory that is grounded on the transaction processes of mutual goal setting between patient and nurse in achieving positive patient outcomes. The theory focuses on perception, stresses the need for listening, and elucidates the interaction of humans with their environment, of which the nurse is an integral part. Interpretive phenomenological analysis, or IPA, is an approach to qualitative, experiential, and psychological research, having been informed by concepts and debates from phenomenology, hermeneutics, and idiography. As such, it was the method used to conduct this study, exploring through semi-structured interview questions the essence of what it means to *be* or *experience* something. Data analysis produced 13 super-ordinate themes reflecting listening behaviors, non-listening behaviors, and outcomes related to each. Participants agreed that the perception of nurse listening has produced improved outcomes for patients with whom they interact and that non-listening nurse behaviors had detrimental effects. Questions within the HCAHPS "Communication with Nurses" domain measure patient perceptions of nurse listening because when nurses are perceived to be listening, the patient experience is improved. Evidence that the improved experience has been linked to improved health behaviors has aligned with the results of this study. For inpatient nurses to reflect on and improve their interactions with patients, ultimately improving patient outcomes, they need to know how their behaviors are perceived and work to adopt those that support the patient while discarding those that are untherapeutic.

*Keywords:* nurse listening behaviors, King's Theory of Goal Attainment, perception, patient experience, qualitative, interpretative phenomenological analysis

## TABLE OF CONTENTS

Dedication ..... iii

Acknowledgments ..... v

Abstract ..... vii

List of Tables ..... xvi

List of Figures ..... xvii

Chapter Page

1. Introduction ..... 1

Statement of the Problem ..... 2

Clinical Rationale ..... 3

Nursing Ethics ..... 4

Financial Rationale ..... 5

Educational Rationale ..... 6

Spiritual Rationale ..... 6

Study Purpose ..... 7

Philosophical Perspective: Phenomenology ..... 8

Theoretical Framework: King's Theory of Goal Attainment ..... 9

Theory Background and Overview: King's Conceptual Systems Model ..... 9

King's Theory of Goal Attainment ..... 11

Chapter Page

The Importance of Concepts in King's Theory .....13

Application to the Study .....15

Literature Supporting the Use of King's Theory of Goal Attainment .....19

Study Significance .....21

2. Review of the Literature .....23

Criteria for Literature Search .....24

Search History .....24

Phase I .....24

Phase II .....27

Phase III .....33

Summary of Key Concepts in the Literature .....37

Listening as Caring .....38

Nurses as Communicators .....39

Lack of Listening .....40

Listening Behaviors .....40

Outcomes of Listening .....41

Satisfaction Versus Experience .....42

Link to Safety .....43

Target Population .....44

Gaps in the Literature .....46

Conclusion .....47

3. Methods .....48

Chapter Page

Choice of Methodology ....48

Study Participants ....50

Sample Selection....50

Sample Size....52

Setting ....52

Nurse Demographics....52

Protection of Human Subjects ....53

Pilot Study....54

Data Collection ....54

Data Collection Sources....55

Interview Site....56

Interview Guide ....57

Data Analysis....58

Data Analysis Plan using Interpretative Phenomenological Analysis (IPA) ....59

Rigor ....65

Auditability ....67

Trustworthiness....68

Dependability....70

Confirmability....71

Transferability....71

Data Management ....72

Chapter Page

De-identification ....72
Transcription ....73
Safekeeping ....73
Conclusion ....74
4. Results ....75
Setting ....75
Study Participant Demographics ....76
Member Checking ....79
Research Question 1: Which Nurse Behaviors Implied Listening Had Occurred and What Were the Emergent Themes? ....82
Making a Connection ....83
Putting the Patient at Ease ....91
Ensuring Safe Care ....96
Research Question 2: Which Nurse Behaviors Implied Listening Had Not Occurred and What Were the Emergent Themes? ....100
Arrogance ....101
Abuse of Power ....108
Incivility/Insensitivity ....113
Abrogating Professional Role Responsibilities ....119
Research Question 3: How Did the Perception of Listening and Nonlistening Affect the Patient, Both In and Beyond the Hospital, and What Were the Emergent Themes? ....126

Chapter Page

Outcomes from Listening ....128

Outcomes from Not Listening ....136

Research Question 4: What Advice do the Participants Have for Nurses as it Relates to Listening? ....144

Connection ....145

The Environment ....145

Listening ....146

Time ....146

Trust ....146

Valuing the Patient's Perspective ....146

What Nurses Should Do ....147

What Nurses Should Not Do ....148

Summary ....149

5. Discussion ....150

Use of the IPA as the Qualitative Method ....150

Link to Theory ....152

Question 5: Demographic Considerations ....157

Expectations and Findings ....159

Codes and Themes Supported by Literature ....159

Unexpected Findings ....163

Expected Findings ....166

Study Rationale Support ....170

Chapter Page

Clinical Rationale....171

Ethical Rationale....171

Financial Rationale....172

Educational Rationale....172

Spiritual Rationale....173

Advice for Nurses: Takeaways from the Participants....173

Study Strengths....174

Study Limitations....175

Implications for Nursing....175

Education....175

Practice....176

Administration....176

Ethics....176

Theory Development....177

Recommendations for Future Research....177

Conclusion....178

References....180

Appendix Page

A. Target Population Demographics....201

B. Facts About Older Americans....203

C. Recruitment Letter....206

D. Participant Demographic Data Collection Sheet....208

Appendix Page

E. Prescreening Inclusion/Exclusion Script .....210

F. Original Recruitment Facility Demographics .....212

G. California Nursing Workforce Demographics .....214

H. Informed Consent .....216

I. No-cost and Low-cost Resources .....220

J. Instrument: Semi-structured Interview Questions .....223

K. Additional Facility Demographics, Parts A and B .....226

L. Participant Demographic Representation .....229

## LIST OF TABLES

Table 1: Summary of Listening Behaviors from Phase I Search ..... 26

Table 2: SPIDER Terms - Phase II Search ..... 28

Table 3: SPIDER Terms - Phase II Search, Revision 1 ..... 30

Table 4: Summary of Listening Behaviors for all Search Phases ..... 42

Table 5: Employed Credibility Threat Mitigation Tactics ..... 72

Table 6: Study Participants' Demographics ..... 77

Table 7: Patient-identified Listening Behaviors ..... 84

Table 8: Patient-identified Listening Behaviors with Themes ..... 85

Table 9: Patient-identified Nonlistening Behaviors ..... 102

Table 10: Patient-identified Nonlistening Behaviors with Themes ..... 103

Table 11: Patient-identified Outcomes ..... 127

Table 12: Patient-identified Outcomes with Themes ..... 129

## LIST OF FIGURES

Figure 1: King's Conceptual Systems Model (KCSM; King, 2007, p. 6) ..... 10

Figure 2: King's Theory of Goal Attainment (KTGA) ..... 12

Figure 3: Participant Ethnicity ..... 79

Figure 4: Participant Sex, Age, Marital Status, Education ..... 80

Figure 5: Participant Length of Stay, Culture, Days Since Discharge, and Reason for Hospitalization ..... 81

Figure 6: Adapted KTGA to Reflect Negative Perceptions ..... 155

# CHAPTER 1

# INTRODUCTION

In the United States, listening has been codified into the standards of professional nursing practice under the banner of communication, of which it is a sub-objective (American Nurses Association [ANA], 2010a). Because it has been linked to an enhanced patient experience and improved patient outcomes, nurse listening has been considered important enough that the U.S. Centers for Medicaid and Medicare Services (CMS) solicit patient perception of its occurrence through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (CMS, n.d.). However, little can be found in the published literature describing which nursing *behaviors* patients perceive as listening behaviors. Indeed, in its 2008 white paper, the International Listening Association (ILA) noted that the processes involved in listening were mainly cognitive, whereas "listening is perceived behaviorally" (ILA, p. 1), making the study of listening a challenge. Many research reports have focused on nurse caring and made such statements as "It has been shown that behaviors such as active listening…can induce [*sic*] the patients a sense of being respected" (Soliman, Kassam, & Ibrahim, 2015, p. 38), but whether nurse behaviors were perceived by the patients as active or passive listening were not addressed. In the study of nurse caring behaviors just mentioned, "listening" was mentioned only once with the presumption that the reader understood its meaning.

## Statement of the Problem

Davis, Thompson, Foley, Bond, and DeWitt (2008) noted that the documented benefits of effective listening in the health care context were threefold: (a) improved emotional and functional status validated by physiological measures; (b) increased adherence to interventions prescribed by the healthcare team with improved ability to remember what was taught in the healthcare setting; and (c) improved quality of life in some settings. Hence, Davis et al. hypothesized that, because unique sets of barriers and variables affected listeners in different contexts, listening definitions also needed to be contextualized. Perceiving that time constraints and a general shortage of available nurses in modern healthcare have impacted nurses' abilities to spend time with the patient, Davis and colleagues (2008) then concluded that clinical outcomes may have been compromised. Their subsequent quantitative study results indicated that there was a gap between nurses' subjective concept of listening and nurses' behaviors (Davis et al., 2008). The concept of listening, in general, may well be one with which every person is familiar but one that most have neither taken time to define for themselves nor questioned the impact of any associated behaviors. Thus, for nurses, assumptions related to listening behaviors may live in the subconscious and a mismatch between conceptualization and actual practice of these behaviors may exist. Thus, there is the need to ask the beneficiaries of care to clarify their expectations.

Too often we have undervalued the power of a touch, a listening ear, or the smallest act of caring, all of which had the potential to turn a life around, as has been true in my many years of nursing practice. For inpatient nurses to reflect on and improve their interactions with patients, ultimately improving patient outcomes, they need to

know how their behaviors are perceived; e.g., which need to be developed and which need to be avoided. Understanding the ways in which patients perceive nurse behaviors that reflect listening is important for a variety of reasons, including those that are clinical, ethical, financial, and educational.

**Clinical Rationale**

There has been a dearth of literature specifically focused on *nurse* listening. Often the construct has been subsumed under broader categories such as caring, presence, or empathy, making it necessary to explore these potentially related topics (Mattila, Kaunonen, Aalto, & Astedt-Kurki, 2014). When listening has been mentioned, it usually has been in terms of outcomes, not the specifics of the behaviors associated with it. Bryant (2009) noted that listening by health practitioners in general produces improved outcomes for patients with whom they interact, possibly because it established rapport. Kawamichi et al. described active listening as "empathic understanding, unconditional positive regard, and congruence behavior" (2015, p. 16), which could also improve the experience for the speaker, for example by helping nurses find personal renewal and healing meaning in their practice, a potentially positive biproduct of intentionally empathic behaviors (Pipe et al., 2008). The HCAHPS survey measures patient perceptions of nurse listening because when nurses were perceived to be listening, the patient experience has improved (Hendrich & Chow, 2008; American Sentinel University, 2012).

The improved patient experience, sometimes termed *satisfaction*, has been linked to improved health behaviors (Wanzer, Booth-Butterfield, & Gruber, 2004). In a study by Lelorain, Bredart, Dolbeault, and Sultan (2012) it was shown that, without healthcare-

related empathy—to which listening is integral—patients seemed to recall less information and retained less knowledge, potentially having a significant impact on their self-care after leaving the hospital. In one systematic review of 55 studies by Doyle, Lennox, and Bell (2013), the link between patient experience and clinical safety and effectiveness was consistently demonstrated inclusive of many contexts, diagnoses, outcome measures, and study designs.

**Nursing Ethics**

As in all professions, nursing has as its cornerstone a commitment to ethics and ethical practice. That foundation should be understood and acted upon by each profession's adherents. Whereas acting ethically is a professional obligation, the way in which ethics should be operationalized within nursing may be acted upon differently by different nurses; hence, ethical expectations are codified by the American Nurses Association (ANA) in its publications *Code of Ethics with Interpretive Statements* (ANA, 2015a) and *Nursing Scope and Standards of Practice* (ANA, 2015b).

As noted by Youl and Bush (2017), beyond the regulatory requirements for nurses to practice ethically, "we have ethical obligations as humans, colleagues, family members, and friends, to listen effectively" (p. 1). In the latter ANA guidebook listed above, the seventh standard of professional performance is entitled "Ethics." Of the 10 registered nurse competencies listed for this standard, four can be directly related to the need for listening. They encompass the following:

- Preservation of patient autonomy and dignity
- Understanding that the patient and family are members of the healthcare team
- Assisting patients to make informed decisions

- Maintaining a therapeutic patient-nurse relationship (ANA, 2010b)

Florence Nightingale, whose life's work focused on creating an environment conducive to patient well-being, also addressed nurse presence and listening as essential components of a healing environment. In her *Notes on Nursing: What It is and What It Is Not* (1969), first published in the United States in 1860, she wrote:

> All hurry or bustle is peculiarly painful to the sick…. The friend who remains standing and fidgeting about while a patient is talking…to him, or a friend who sits and proses, the one from an idea of not letting the patient talk, the other from an idea of amusing him—each is equally inconsiderate. Always sit down when a sick person is talking…to you, show no signs of hurry, give complete attention and full consideration…. (p. 48-49)

**Financial Rationale**

Every acute-care hospital in the United States that bills CMS for services rendered has been subject to publicly-reported patient ratings obtained derived from the survey instrument called HCAHPS (Press Ganey, 2018; CMS, n.d.). Of the 10 measures—or domains—of care, six are composites, one of which is a group of three sub-questions related to communication with nurses. This domain has had the greatest impact on how patients perceive their hospital experience (Sofaer, Crofton, Goldstein, Hoy, & Crabb, 2005). Additionally, positive patient experiences or outcomes have been shown to be closely associated with effective interactions between patient and the healthcare team (Lane, Hamilton, MacDonald, Ellis, & Howie, 2016). Because the scores from the HCAHPS survey have been publicly reported, patients have used the results to make choices about where to receive their care. These choices can affect the hospital's

standing in the community and, thus, its viability. The other financial consideration has been the direct impact HCAHPS scores have had on a facility as it relates to the fiscal penalties levied by CMS for poor scores (CMS, 2017).

**Educational Rationale**

Van der Elst, Dierckx de Casterle, Biets, Rchaidia, and Gastmans (2013) studied the characteristics of the "good" nurse from the patient perspective. They observed that what most affected the patient perception was the individual nurse and the nature of the nurse-patient relationship. With that knowledge, they suggested that sharing patients' perceptions of what makes a good nurse was important for nursing education; to wit, nursing educators should emphasize the fact that often a gap existed between nurse and patient perceptions.

Although improving patient outcomes was the desired goal, all rationales are valid reasons for making the case that nurses require listening competency. Hence, the need has existed for a clear understanding of what those listening competencies might be, so they can be taught and measured (American Sentinel University, 2012).

**Spiritual Rationale**

Spirituality encompasses thoughts and practices that allow human beings to seek truth in relation to themselves, to others, and to a higher power (Schnapp, 2008). It involves a connection with entities beyond oneself, including one's environment. While a patient is hospitalized, the nurse is part of that environment and, thus, plays a role in the wholistic care of the patient. The idea of pastoral care (related to spiritual care) has existed as emotional and spiritual support since ancient times in all cultures and traditions (University of Canberra Multi-Faith Centre, 2012). Although pastoral care often has

been relegated to a designated person other than the nurse, much of the role also has been within the nurse's purview as it included nonreligious forms of support as well as those of a religious nature. According to Schnapp (2008), "the practice of pastoral care rests on listening effectively" (p. 136). Even though they have been based on perception, behaviors associated with this aspect of care have included "openness, availability, confirmation of the other, responding with and encouraging the use of feel-language, awareness, empathy, and the skills of therapeutic and empathic listening…" (Schnapp, 2008, p. 136-137). To clarify, *feel* language includes words that connote sensations, moods or emotions, and dispositions such as love—all independent of mood (Angelo, 2007). All these have been part of the caring arsenal used often by nurses. Hence, a greater awareness of and a change of behavior related to the way in which listening has been perceived could yield a sense of empathic and supportive care.

## Study Purpose

The purpose of this study was to understand patient perceptions of nurse listening behaviors. The specific aims were to discover, describe, interpret, and categorize patient perceptions of nurse listening behaviors and determine how these behaviors may impact patient outcomes and the healthcare experience. Thus, the study was designed to answer the following questions from the patient perspective:

(a) which nurse behaviors implied that listening had occurred, and (a.1) what emergent themes arose from the data;

(b) which nurse behaviors implied that listening had not occurred, and (b.1) what emergent themes arose from the data;

(c) how did the perception of both listening and nonlistening affect the patient, both

in and beyond the hospital, and (c.1) what emergent themes arose from the data; (d) what advice do the participants have for nurses as it relates to listening?

## Philosophical Perspective: Phenomenology

Made popular in the 20th century by German philosopher Edmund Husserl in opposition to the "context-free" empirical approaches to research, phenomenology's founding principle was that "experience should be examined in the way that it occurs, and in its own terms" (Smith, Flowers, & Larkin, 2012); the nature of the experience involved the natural world (Blackburn, 2008). Phenomenology as a study pursues seeks a deeper than usual foray into the meaning of everyday experiences (Munhall, 2012). The phenomenological approach to research seeks process, not outcomes, and the understanding of human behavior through the lived experience or eyes of another (Neutens & Rubinson, 2010). Instead of looking at experiences as having causal relationships or empirical justification, phenomenology is a subjective look at life (Benhke, n.d.). Hence, because, upon reflection, our subjective experiences *appear* to us, they are called phenomena (Smith et al., 2012). Biemel and Spiegelberg (2017) explained that these phenomena should be, as far as is possible, examined without a priori suppositions and preconceptions. The idea was and is to get to the essence of what it means to *be* or *experience* something.

Husserl's was an all-encompassing search for the essence of experience, one that required the investigator to enter the relationship with no preconceptions or presumptions and to apply no structure to the interview (Neutens & Rubinson, 2010). A narrower focus can be attributed to the work of Martin Heidegger, Husserl's student, who felt Husserl's approach was too abstract and questioned the ability of researchers to remove

themselves completely—or bracket—from the phenomenon they were studying. Heidegger (1962) maintained the idea of contextualized experiences as being in the world culturally, socially, and historically. Munhall (2012) wrote that a person's background—through language and culture—provides the conditions in which human actions and perceptions occur. Schnapp (2008) noted that a person's cultural background may impact the way information is processed. Finally, Heidegger emphasized the centrality of language and linked it to thought and perception (Munhall, 2012).

## Theoretical Framework: King's Theory of Goal Attainment

### Theory Background and Overview: King's Conceptual Systems Model

A grand theory and the precursor to King's theory of goal attainment, King's conceptual systems model (KCSM) has become well-known, having stood the test of time and scrutiny. Its historical development has been well documented and has included influences from other disciplines and scholars. There has been ample literature support for the use of the grand theory in both knowledge building and as a springboard for the development of middle range theories (Frey, Sieloff, & Norris, 2002), thus, supporting its importance. The theory addresses all four metaparadigms of nursing: (a) nursing, (b) person, (c) environment, and (d) health (Sieloff-Evans, 1991). Its focus on outcomes has undergirded the importance of nurse listening as have King's own words, which convey that listening, along with goal setting, has been and continues to be one of the most important aspects of nursing care (King, 1981).

King's framework for nursing as delineated in the KCSM (Figure 1) shows the interaction of three human dimensions: personal systems— (a) those at the level of the individual system, (b) interpersonal system used within groups, and (c) social systems

used within the broader societal setting (King, 2007). Nursing's focus was on the interaction between human beings and their environment (Sieloff-Evans, 1991) and its function included "the interpretation of specific information" (King, 1981, p. 8) garnered through the efficient gathering of data. According to Fawcett and DeSanta-Madeya (2013), King regarded all dimensions as being "connected through communication that is targeted to goal-directed behavior" (p. 85). King (1981) wrote that human beings react based on their "perceptions, expectations, and needs" (p. 20).

As can be inferred from the model and is clear in King's writing, the overall assumption underlying this theory was that, as a discipline, nursing focuses on the interaction between human beings and their environment, affecting their health (King, category of interpersonal relationships (Fawcett & DeSanto-Madeya, 2013). King (2007) 2007)—a unique focus of King's conceptual system, a system classified within the

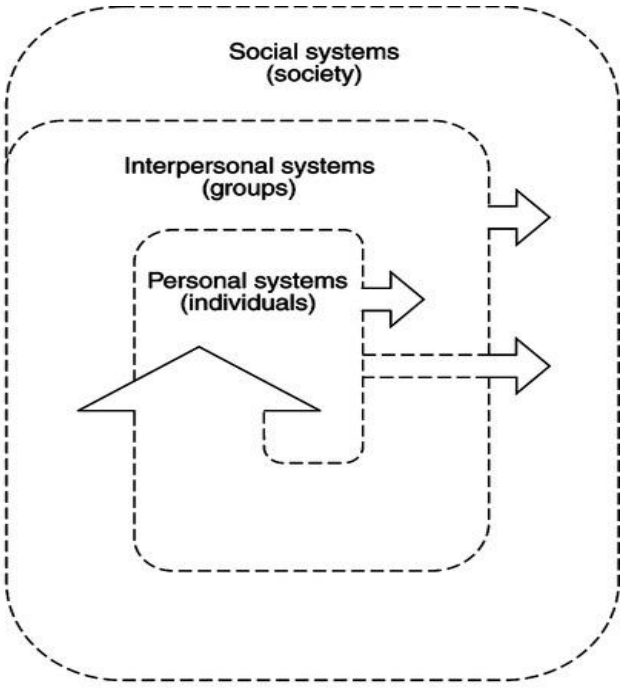



*Figure 1*. King's conceptual systems model (KCSM; King, 2007, p. 6).

also clarified: “Specific assumptions about human beings are that they are social, spiritual, sentient, rational, reacting, perceiving, controlling, purposeful, action-oriented, and time-oriented” (p. 109).

**King’s Theory of Goal Attainment**

A middle range theory derived from KCSM, King’s theory of goal attainment (KTGA) has been grounded on the transaction processes of mutual goal setting between the patient and the nurse in achieving positive patient outcomes. The theory focused on this process to guide and direct nurses in the nurse-patient relationship, as nurses collaborated with their patients to meet the patients’ health goals (Wayne, 2014). Although the theory is too abstract to have had a direct application to practice, its *concepts* can be applied (Sieloff-Evans, 1991). Further, it has elucidated the interaction of humans with their environment and given attention to the continuing ability of individuals to meet their basic needs so that they can function in their socially-defined roles (Sieloff-Evans, 1991). The focus is on human beings—on their behaviors, social interactions, and social movements. KTGA was chosen to guide this study because of the intentional focus throughout the theory on perception, from the vantage point of both the patient and the nurse. This emphasis has worked especially well for this study where the focus was on the patient’s perception of nurse listening behaviors. It also has spoken to the outcomes that occur based on the perceptions and interactions—an important element of this study.

Perception is one of the key concepts within KTGA (see Figure 2). This theory was based, in part, on the assumption that “individuals are perceiving beings” (Sieloff-Evans, 1991, p. 28). Not only do they interpret another’s intention by their behavior, they

also have perceptions related to their care or their health that, to be discovered by the individual, require interaction and communication between nurse and patient . Ultimately, the perceptions of both nurse and patient influence the ensuing interaction and, ultimately, transaction—another of the theory's assumptions.

Perceptions are one's own reality; judgments made by inferring the meaning or intent of others' behaviors. Nurses' perceptions regarding patients lead to personal or professional judgments and, ultimately, to action by the nurse. Reciprocally, the patient's perceptions of the nurse also lead to judgments and actions by the patient. Reflecting a world view that embraced reciprocal interactions, King believed that these interactions could and would impact patients' health and that human beings were active participants

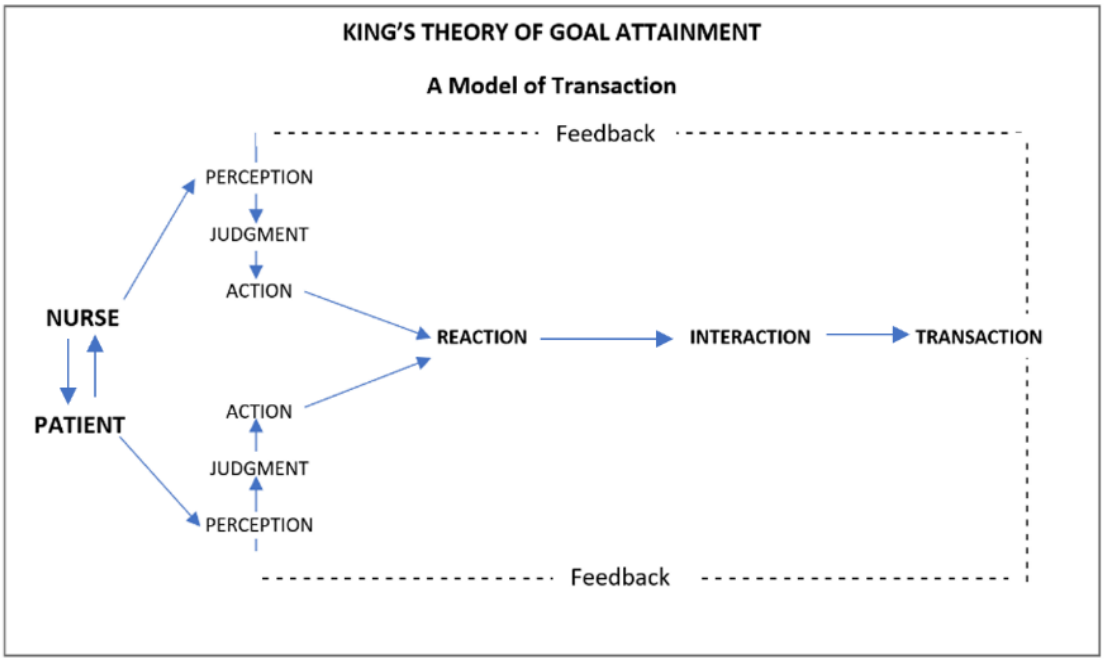



*Figure 2*. King's Theory of Goal Attainment (KTGA). Retrieved from *King's Conceptual System, Theory of Goal Attainment, and Transaction Process in the 21st Century*, by I.M. King, 2007.

in interacting with each other (King, 1981; King, 1999; Fawcett & DeSanto-Madeya, 2013). The idea of active participants is important because listening is not a passive endeavor and is, as seen in King's later writings, observable in what she termed the "concrete situations in nursing practice" (King, 1996, p. 62).

**The Importance of Concepts in King's Theory**

Sieloff-Evans (1991) listed six concepts Dr. King considered particularly relevant to the personal system. Perception was one of the concepts most germane to the research question. King made assumptions about the patient-nurse interaction, one of which was that the perceptions of the nurse and those of the patient influenced the communication process (King, 1981). As the nurse and the patient responded to their perceptions of each other, reaction, another part of the interaction-transaction process, occurred (Fawcett & DeSanto-Madeya, 2013). One of seven dimensions of King's personal system domain, perception was considered a major contributor to the process of human interaction (Fawcett & DeSanto-Madeya, 2013). Perception was defined as that which individuals believed to be real within their lives and environment and occurred using both physical or sensory and intellectual tools (King, 1981). Perception differed for everyone because of its relation to person-specific factors such as experience, education, self-concept, socioeconomic status, needs, goals, temporal-spatial relationships, physiology, and values (King, 1981).

Judgment was another relevant concept from the model. It was part of what is described as "interpersonal agency," or "the ability to accurately judge others' emotions, intentions, traits, truthfulness, and other social characteristics" (Schlegel, Boone, & Hall, 2017, p. 103). The sender of a message used cues such as physical appearance and/or

verbal and nonverbal behaviors. The receiver interpreted (judged) the other based on these cues during their mutual interaction; however, not all cues would be interpreted with the same lens (Schlegel et al., 2017). This concept is related to this study because as the nurses' behaviors sends messages to the patients, the patients *independently* perceive the intent, such as whether the nurse is listening; that is, what may be implied by the sender may not be inferred by the receiver (Schlegel et al., (2017) also noted that different categories of judgments "might be influenced by different individual characteristics, traits, and self-perceptions of the judge" (p. 108). Hence, pertinent demographic data was collected for each participant to determine whether such factors might impact perceptions.

King's theory and its corresponding pictorial representation (Figure 2) highlights a process of interaction, including (a) action, (b) reaction, (c) interaction, and (d) transaction, all used by the nurse to help individuals meet their goals (Wayne, 2014). The process of interpersonal perception and communication—both verbal and nonverbal—was considered an interaction in KTGA. When therapeutic, this process has led to the fulfillment of a goal or a transaction (Wayne, 2014). In psychology, reaction, interaction, and transaction are considered part of a "functional relationship between two or more interactants' overt interpersonal behavior" and the concealed experience of that interpersonal behavior and experience (Wagner, Kiesler, & Schmidt, 1995, p. 938). This model, known as the interpersonal transaction cycle, highlights the idea of an interconnectedness within social transactions in which the interpersonal behavior of each participant has caused and influenced the behavior of the other person in the dyad (Wagner et al., 1995). As the overt behavior of one elicited a covert reaction from the

other, that reaction influenced further overt behavior of the first participant. The two behaviors (overt and covert) functioned as a unit. This idea supports King's TGA.

**Application to the Study**

Because of KTGA's emphasis on perceptions, interaction, communication, judgment, action, reaction, transaction, and goal attainment (Figure 2), the theory has aligned well with the study's focus on patient perceptions of nurse listening behaviors leading to improved outcomes. Listening is a major component of communication.

Part of perception involves the processing of information (Sieloff-Evans, 1991). King (1981) affirmed that the accuracy of a patient's perception was dependent upon validating with the patient the interpretations made by the nurse. This validation has been linked to at least one of the documented verbal cues related to listening in general: paraphrasing for enhanced understanding, (discussed further in the review of the literature). In the context of clinical health care safety, this method has been called "repeat back" and has been used to ensure that the receiver heard the message in the way the sender meant to communicate it (KentuckyOne Health 2012). The intent was the same whether the intended goal was safety or some other outcome. Although the action of repeating back is not the same thing as the concept of understanding, it is a good first step.

Additionally, much of human interaction relies on communication, a dimension of the interpersonal system that, in general, allows humans to connect. For the purposes of this study, it is a means of establishing goals within the nurse-patient relationship. This communication is ultimately influenced by both parties' perceptions. Together, perception and communication define interaction, a process which includes both verbal

and nonverbal behaviors (King, 1981). In alignment with the literature, King (1981) and Sieloff-Evans (1991) described the two modes of communication as verbal (V) and nonverbal (NV), with King further noting the extreme importance of NV communication in accurately providing information about another's attitudes and feelings, and as a key factor in the success of any mutually-determined goal-setting. Illustrations of NV communication in King's 1981 treatise included (a) presence, (b) detachment, (c) facial expressions, (d) bearing, and (e) touch. She has also noted the importance of listening, being silent, and observing the way in which a person communicates without words. Ultimately, perceptions of both sender and receiver were integral to communication (Sieloff-Evans, 1991).

King (1981) found that a transaction was observable and goal-directed—an interaction with one's environment. The nurse was part of the patient's environment and brought with him or her observable behaviors with the intent of setting achievable goals with a patient. King has written that variables related to the nurse and patient interaction occurred because of both persons' knowledge, experience, objectives, ideals, and situational perceptions (1981). Verbal and nonverbal communication modes were present in every interaction, in turn influencing the perceptions of both parties (Sieloff-Evans, 1991).

King (1981) has found that successful interpersonal transactions often reduce tension and stress, giving the nurse even more motivation to make transactions as efficacious as possible. This result may be an unintended but welcome outcome. Fawcett and DeSanto-Madeya (2013) have described King's view of feedback as an

integral part of the open systems model supporting her theory—a dynamic that occurs continuously between nurse and patient.

One dimension of interest within King's Social System is the concept of authority (Sieloff-Evans, 1991). Fawcett and DeSanto-Madeya (2013) paraphrased King's definition of "authority" as "a process that is characterized by active, reciprocal relations that reflect how one person influences others" (p. 87). This represents the role nurse listening plays and the impact behaviors that reflective listening can have on patients. The process of listening is active and intentional, as discussed below in the review of the literature. It also requires two people to fulfill a reciprocal relation. The idea of the term authority being used in this way also relates back to the theory's concepts of action, reaction, interaction, and transaction. As one perceives listening has or has not occurred within his or her interpersonal interaction, one will react with some behavior (e.g., sharing more versus withholding information, fears, ideas, or questions) that is foundational to future interactions. A transaction will have occurred.

King's focus on perceptions makes this theory particularly compelling for use with the study's focus on patients' perceptions. As long ago as 1981 in her book *A Theory for Nursing: Systems, Concepts and Process*, King identified the importance of perceptions. She wrote, "Perceptions of nurse and client influence the interaction process…. Health professionals have a responsibility to gather relevant information about the client so that their goals and the goals of the client are congruent" (p. 143). She specifically identified perception as a subcategory in both her theory's human beings domain under the personal system, and in nursing under the interaction-transaction process (Fawcett & DeSanto-Madeya, 2013).

The basis of the proposed research is that the patient (otherwise known as "client" in some of King's writings) must perceive that the nurse is listening for him or her to share relevant and meaningful information and participate in the setting of reasonable and achievable goals that would lead to improved outcomes. If the patient does not perceive that listening has occurred, the connection will not be as robust, trust may be lost, and outcomes could suffer.

Other categories pertinent to the phenomenon of interest are concepts associated with human beings (a domain) and interaction-transaction (a process), as discussed above. These concepts include (a) interaction, (b) communication (both verbal and nonverbal), and (c) perception. These are the very dimensions of the nurse-patient interaction that seemingly support or are the natural outcomes of nurse listening.

Interaction occurs by nature of the relationship. Listening involves both verbal and nonverbal skills. In King's model these skills are listed as part of communication of which listening is an integral part. Perception occurs on both sides of the bedrail. While the nurse is perceiving the patient's affect and understanding, the patient perceives whether the nurse is listening, among other things, based on his or her interpretations of the nurse's actions. Some actions will occur after the interaction between patient and nurse. Whether an action is goal-oriented, aligned with improved outcomes, or signals a retreat into past patterns of health behavior may depend on this interaction (Frey et al., 2002). In the case of listening, patients perceive whether they are heard.

Application of the TGA has been shown to be helpful in the development of research hypotheses and in nursing practice (Sieloff-Evans, 1991). As Dr. King notes, the TGA "provides a theoretical base for nursing process as it demonstrates a way for

nurses to interact purposefully with [patients]" (1981, p. 176). This study has focused on the ways in which patients perceive specific nurse behaviors and link them to "listening" and, with equal importance, to "not listening." Then, with a better understanding of the patient point of view, current and future registered nurses (a) can use that knowledge to reflect on their current behaviors, (b) be more intentional in their patient interactions, and (c) embrace the potential benefits perceived nurse listening has on patient trust, feelings of safety, information recall, and other beneficial outcomes yet to be discovered.

**Literature Supporting the Use of King's Theory of Goal Attainment**

Just as this study is based on the theory of goal attainment created by Dr. Imogene King, other health care-related studies utilizing KTGA can be found in the literature. Examples of such studies are presented here. The theory has been used in a variety of settings and was recently applied to the challenges of using technology to enhance nursing care and education (Fronczek, Rouhana, & Kitchin, 2017).

In 1988, Gulitz and King developed a model that based the development of a nursing curriculum on King's TGA. The conceptual framework of KTGA served as a guide for developing the curriculum objectives. In these early years of the theory's dissemination, the model clarified "the relationship of individuals and families to communities by using concepts that define personal, interpersonal, and social systems" and used "concepts, axioms, skills, and values as the central components of the curriculum" (Gulitz & King, 1988, p. 128).

Hampton (1994) used the TGA as an implementation framework in a hospital setting. The reason for its use in this situation was the belief that the "implementation of nursing conceptual frameworks and theories in practice settings is essential to foster the

growth and advancement of the discipline of nursing" (p. 170). Specifically, this study focused on how KTGA could serve as a nursing framework for implementing managed care.

In a 2006 study, Cheng used KTGA to determine the cause of multiple hospital readmissions of a schizophrenic patient. When the cause was determined to be medication nonadherence, the team, based on goal-attainment theory, worked mutually with the patient to individualize his care plan and meet his needs. The results indicated that KTGA was of benefit to both the patient and his family, as it led to the patient taking more responsibility for managing his condition. This, in turn, led to fewer hospital readmissions and the ability of the patient to maintain his desired level of socialization.

A recent article reflected a process improvement project using King's conceptual system and TGA as its foundation (Fronczek, Rouhana, & Kitchin, 2017). In the review of the TGA, the authors discussed the requirements and proficiencies nurses need to successfully interact with patients to mutually set goals. They noted that much of the expertise needed to have a successful patient-nurse interaction was related to excellent listening and communication skills. Fronczek et al. (2017) noted that these attributes were a trademark of King's work and were consistent with the assumptions underlying their study. They acknowledged that the interactions described by King were often now being facilitated by technology. Acknowledging that this change was occurring, they used King's conceptual framework to support curriculum changes and create an environment that would support discussion of the potential uses for telehealth (Fronczek et al., 2017).

In another recent study, South Korean researchers applied KTGA to create goal-oriented strategies and apply them to patients with a first episode of acute myocardial infarction. Using these strategies, they sought to modify behavior through mutually-agreed upon goals that were based on mutually-agreed upon risk factors (Park, Song, & Jeong, 2017). The study's results showed improvement in three important areas: (a) blood pressure reduction, (b) health behaviors, and (c) certain aspects of quality of life.

## Study Significance

Perception matters. There is often a gap between self-perception and the perception others have towards the listening and caring behaviors of the nurse Papastavrou, Efstathiou, and Charalambous, 2011; Isaac, Behar-Hornstein, Davis, and Graff, 2011; Van der Elst et al., 2013; Schindler et al., 2017). For example, in the study by Martensson, Carlsson, and Lampic (2010), nurses' perceptions of the comfort they gave to a subset of patients was not substantiated by the patients' ratings of that care. Thus, if the patient does not perceive that a nursing intervention such as listening has occurred, then the intervention most likely has not been effective in reaching the desired goal (Martensson et al., 2010). Pipe et al. (2008) and Haley, Heo, Barone, Rettiganti, & Anders, (2017) have agreed that raising awareness among nurses of the positive impact active listening has on patients, both in and beyond the hospital, was an opportunity that must be seized. However, if such actions have not been perceived to have occurred, then they cannot provide the therapeutic benefits for which they were meant. That is why understanding the patient perspective is crucial.

After completing their cross-cultural study of caring behaviors within the European Union, Papastavrou et al. (2011) concluded that "further research is needed in

other patient populations using different approaches which could explore patients' experience more in depth" (p. 1035), a conclusion aligned with the intent of this study. Additionally, because nurses should always practice reflexively and communicate frequently with their patients about the patient's care experience no matter the setting (Schindler et al., 2017), the goal is to get nurses involved in understanding their own practices and bridging the gap between their self-perceptions and the patient perceptions of the nurses' ability to act as effective listeners.

Several anticipated study benefits include (a) an increased nurse awareness of the way patients perceive their behaviors, and (b) the opportunity for nurses to close the gap between nurse and patient perceptions of listening behaviors by improving their listening skills. This can be accomplished by sharing the study's results with nurses and nursing management. Nurse communication, which includes effective or therapeutic listening, is a competency that is highlighted in the ANA Standards of Professional Nursing Practice (ANA, 2010). Standard 11 states that the registered nurse "assesses her or his own communication skills in encounters with healthcare consumers, families, and colleagues" (ANA, 2010, bullet 2). It is anticipated that comparing assumptions with actual patient feedback will prove to be insightful and, ultimately, will provide a catalyst for behavior change.

# CHAPTER 2

# REVIEW OF THE LITERATURE

"Good listening is…fundamental to effective nursing practice" (Gilbert, 2004, p. 447), critical to a healthcare professional's competence (Roter & Hall, 2006), and an essential element in patient satisfaction and patient-centered care (Geist-Martin & Bell, 2009). Listening has been defined as "the process of receiving, constructing meaning from, and responding to spoken and/or nonverbal messages" (Davis et al., 2008, p. 153). Since learning, like listening, is contextual, nurses and other therapeutic caregivers must understand that actions—both theirs and the patient's—may also be contextual, a result of situated cognition, or perception (Davis et al., 2008).

Davis et al. (2008) did, however, warn that "attitudes toward and beliefs about listening are highly subjective, vary widely among individuals and groups, and build upon past learning" (p. 154). The good news is that it has been possible to objectively measure patient perceptions, thoughts, and feelings (Hall et al., 2015) and the skill of listening has been trainable (Desmond et al., 2014; Hall et al., 2015). These findings bode well for the goal of disseminating this study's results to influence behavior change in nurses.

Ralph Nichols, the de facto "father of listening," has noted that, subjective though the concept is, "[t]he most basic of human needs is the need to understand and be understood. The best way to understand people is to listen to them" (Nichols, n.d.). More

than merely hearing, listening has been described as a process consisting of four stages occurring in sequence but generally not within our awareness: "sensing and attending, understanding and interpreting, remembering, and responding" (Steinberg, 2007, p. 76). However, based on a literature search and according to the literature itself, there has been scarce research that has related nursing behaviors in general—and listening behaviors in particular—to patient outcomes, one of the goals of this proposed research (Papastavrou et al., 2011).

## Criteria for Literature Search

Using the Azusa Pacific University's (APU) online library databases, the articles considered had to be peer-reviewed and written in English and at least after the year 2000—the date range was tightened as the search continued. During each of the three phases of the search history, various terms or combinations of words were used. At a minimum, the words *nurs**, *patient**, and *perception** were included. Databases varied between phases, as described below.

## Search History

### Phase I

**Search procedure.** In phase I, the databases used were APU Encore, EBSCO Host, Google Scholar, MEDLINE, Cumulative Index of Nursing and Allied Health Literature (CINAHL), and EMBASE. The search term words or roots were *nurse* or *nurs**; *listening*; *behavior**, *behaviors*, or *behaviour*; *listening, caring*; *literature review*; *patient*; and *quantitative*.

Many studies were found that highlighted the benefits of listening but did not address which behaviors were associated with the activity (McCabe, 2004; Fassaert, Van

Dulmen, Schellevis, & Bensing, 2007; Davis et al., 2008; Canzan, Heilemann, Saiani, Mortari, & Ambrosi, 2013; Greenstein, Arora, Staisiunas, Banerjee, & Farnan, 2013; Kluger & Zaidel, 2013; Van der Elst et al., 2013; Bodie, Vickery, Cannava, & Jones, 2015; Kawamichi et al., 2015). Indeed, Davis et al. (2008) acknowledged that in healthcare research, listening has not been studied; instead focus has been on patient feelings in relation to the perception of listening.

**Listening concepts.** Assumptions are often made about what behaviors constitute listening from the patient perspective (Davis et al., 2008). Key concepts were similar across the studies in phase I. All but two—Clayton, Reblin, Carlisle, and Ellington, (2014) and Kawamichi et al. (2015)—made the distinction between passive/nonverbal (NV) and active/verbal (V) listening.

***Passive and active listening behaviors.*** Some of the articles listed above did articulate specific listening behaviors, both passive (NV) and active (V), albeit in varied, nonhealthcare contexts; these behaviors have been outlined in Table 1. Though these may be good generalizations of listening behaviors, they may not necessarily reflect the perception or experience of the adult in an inpatient setting.

***Active listening.*** Although the word *active* is associated with V behaviors above, active *listening* also encompasses all the *passive* or NV behaviors listed in Table 1. Mentioned in many articles, active listening (AL) can be thought of as "empathic understanding, unconditional positive regard, and congruence behavior" (Kawamichi et al., 2015, p. 16) and could improve the receiver's impression of his or her experience. Memory retention also was enhanced when AL was employed (Greenstein et al., 2013). Kourkouta and Papathanasiou (2014) noted that listening was foundational to responsible

Table 1

*Summary of Listening Behaviors from Phase I Search*

| Passive/Non-verbal (NV) | Active/Verbal (V) |
|---|---|
| Eye contact | Reading/taking notes |
| Affirmation sounds<br>Nodding | Reflecting feelings |
| Body position (e.g., leaning in) | Notices NV and V signs |
| Uses comfortable silences | Encourages clarification |
| Focuses only on the speaker | Does not interrupt |
| Mirroring behavior of others | Asks open-ended questions |
| Facial expressions (e.g., smiling) | Read-back/paraphrase |

nursing practice that uses all the senses and required great concentration to appreciate both the verbal and nonverbal cues delivered by the patient. As they actively listened, nurses performed a variety of positive interventions, including (a) assessment, (b) enhancement of the patient's self-esteem, and (c) integration of diagnosis and process. When the nurse gave the patient undivided attention, problems surfaced sooner, and the patient gained satisfaction in the therapeutic nature of the relationship. This gets to the heart of communication (Press Ganey, Inc. [PG], 2013).

***Good listening.*** Ceccio and Ceccio (1982) suggested good listening employed the following skills or actions:

- Maintaining eye contact
- Giving full mental and physical attention to the speaker
- Decreasing barriers to listening
- Doing one's best to avoid interruptions

- Responding to both the content *and* the feeling of the message being conveyed
- Listening intentionally for thoughts and themes
- Conveying that the message is understood, by employing such actions as paraphrasing or restating what has been said, and
- Responding to both verbal and nonverbal aspects of the message.

**Phase II**

**Search procedure.** Although specific listening behaviors were found in the literature during the Phase I search, none were specifically related to nursing and none were from the perspective of the adult patient who had received care in an acute care setting. Thus, a standardized, systematic search strategy was used for a second formal literature search to (a) broaden the number of applicable studies, (b) enhance the rigor of the proposed study, and (c) update references by two years. Called the SPIDER tool for qualitative evidence synthesis, this search strategy acronym stands for Sample, Phenomenon of Interest, Design, Evaluation, Research type. Initial search terms used for each of these categories have been listed in Table 2.

In the initial Phase II search, CINAHL with full text was used. Options and limiters included the following:

- Ability to apply related words and find any search terms
- Searchable full text
- Abstract available
- English
- Peer-reviewed

Table 2

SPIDER Terms – Phase II Search

| SPIDER Categories | Search Terms Used |
|---|---|
| **S**ample | "patient" |
| **P**henomenon of **I**nterest | "nurse listening behavior" |
| **D**esign | "questionnaire" or "survey" or "scale" or "instrument" |
| **E**valuation | "perspective" or "perception" or "opinion" or "experience" or "attitude" |
| **R**esearch Type | "qualitative" or "mixed methods" or "quantitative" |

- Date range from 2005-2018
- Human
- Research article
- Inpatients

This configuration with these choices netted 2,011 articles. Many of the resultant articles were outside the intent of the search. Some were duplicates. After searching well down into the list, only five articles with some relevance to the study were found: (a) Zugai, Stein-Parbury, and Roche (2018) conducted their study with a mental health population in Australia; (b) Schindler et al. (2017) gave a case report from the Dominican Republic in the labor and delivery setting; (c) Suliman, Welmann, Omer, and Thomas (2009) reflected on a study that applied Watson's nursing caring theory in a multicultural environment within Saudi Arabia; (d) Papastavrou, et al., (2011) studied cross-cultural perceptions of caring behaviors of both patients and nurses in a population in Cyprus; and (e) Roch, Dubois, and Clarke (2014) discussed how organizational climate affects caring

practices from a study in Quebec, Canada. Two studies (Zugai et al., 2018; Roch et al., 2014) did not mention listening at all but instead wrote of caring practices, love, and/or positive regard. The other three studies listed above (Suliman et al., 2009; Papastavrou et al., 2011 Schindler et al., 2017) mentioned listening from one to four times and only to state its importance. None addressed listening behaviors.

Because the SPIDER categories are split the way they are, the results were reflective of perceptions of many populations not including those of patients. To obtain more applicable articles, the search terms were changed to combine the sample with the evaluation aspects of the SPIDER scheme, as shown in Table 3.

Parameters were also changed from including any search terms to finding all search terms. This yielded a more manageable total of 76 records. Four were accepted. Others were inappropriate for any one of a variety of reasons, such as wrong focus; listening only mentioned without discussing associated behaviors or describing its role in healthcare; listening mentioned in relation to music or patients with aphasia, patient-focused listening problems, or the topic was related to another profession in an unrelated context.

Table 3

SPIDER Terms – Phase II Search, Revision 1

| SPIDER Categories | Search Terms Used |
|---|---|
| **S**ample combined with **E**valuation | "patient perspective" or "patient experience" or "patient view" or "patient perception |
| **P**henomenon of **I**nterest | "nurse listening behavior" |
| **D**esign | "questionnaire" or "survey" or "scale" or "instrument" |
| **R**esearch Type | "qualitative" or "mixed methods" or "quantitative" |

The four that were culled included (a) Pipe et al., 2008, where listening, in some form, was linked to nursing care; (b) Martensson et al., 2010, which linked nurse listening to caring in a Norwegian healthcare setting; (c) Haugan, Moksnes, and Lohre, 2016, a study from Scandinavia with nursing home patients that provided some good insight on nurse-patient interaction; and (d) Timmermann, Uhrenfeldt, and Birkelund, 2017, the first study found that mentioned listening behaviors, although not just of nurses and not just by patients.

However, to be thorough and more inclusive, the search term *behavior* was changed to *behav**. This change led to a total of 45 records, four of which were duplicates of those in the previous search. Three records were deemed applicable: (a) a study from Brazil by Zani, Macron, Tonete, and Parada (2014) that focused on caring in the emergency department; (b) a study by Clukey, Hayes, Merrill, and Curtis (2009) researching family members' perceptions, in which listening was linked to behaviors; and

(c) a study by Wysong and Driver (2009) of patient perceptions of the attributes (such as listening) possessed by a skilled nurse.

The search criteria received one final change with the inclusion of the databases MEDLINE, PsychInfo, PubMed, SAGE Journals, American Doctoral Dissertations, ProQuest Dissertations and Theses, and Google Scholar, and the deletion of CINAHL. The limitation of *all adults* was added where options were offered (e.g., MEDLINE and PsychInfo). The total number of records generated from this new search was 173. Because one chosen search requisite was that there be an abstract, each summary was perused for fit, at minimum. Most articles were scanned in their entirety for inclusion of relevant words and concepts using the Find function within the Adobe portable document files (pdf) format.

**Listening concepts.** From this phase of research were culled four main concepts discussed within these articles.

***Therapeutic alliance.*** In the study by Zugai et al. (2018), therapeutic alliance was defined as interpersonal engagement and a balanced application of authority, requiring nurses to have interpersonal diplomacy and to demonstrate their dependability, leading to patient feelings of safety and well-being. Although the word *listen* was not mentioned, the concept aligned with the idea of presence found in literature on caring that includes listening. Roch et al. (2014) supported the idea of therapeutic relationships through the use of (a) caring practices, (b) purposeful presence, and (c) interaction with patients during nursing activities.

***Not listening.*** Schindler et al. (2017) gave examples of patients feeling as though they had not been listened to, such as having their opinions discounted and being ignored

by the nurses. In a study by Clukey et al. (2009), nurse listening behaviors were perceived by the families of trauma patients, not by the patients themselves. However, as the family has been considered integral to the care of the patient (Kourkouta & Papathanasiou, 2014; Clay & Parsh, 2016), their perceptions should be noted. Nurses' actions that conveyed a sense of being too busy to listen included being abrupt or seeming to be hurried (Clukey et al., 2009). Wysong and Driver (2009) also made note of the perception made by patients' families that not doing as the family had asked was a sign of the nurse not listening.

***Attentive listening.*** Subsumed under the concept of caring and listed with several other attitudes, listening attentively has been considered a top 10 caring behavior and has been associated with demonstrating helping and trust (Pipe et al., 2008; Suliman et al., 2009; Papastavrou et al., 2011) and being a skilled nurse (Wysong & Driver, 2009). Attentive listening has been shown to lead to a positive encounter, has been understood as sincerity and emotional commitment toward the patient, and could be implied by body language and manner (Timmermann et al., 2017). If attentive listening could be equated to attentive presence, then body language and tone of voice were both integral to affirming the patient, making him or her feel heard. As in this study's pilot (discussed in Chapter 3), The 2017 study by Timmermann et al. indicated that patients also linked their subjective perceptions of the nurse's attitude and mood to their perception of nurse listening. Pill (2016), working with physicians in Beirut, coded listening skills under the thematic umbrella of communication skills. Attentive listening was said to be evidenced by noticing patients cues and resisting the temptation to interrupt.

***Caring/listening-associated behaviors*.** In findings by Cluckey et al. (2009), NV behaviors of caring/listening, perceived by the patient's family members, included:

- eye contact and smiling as an important demonstration of caring
- making oneself available
- tone of voice
- pace of actions
- force of actions
- the ability to engage in active listening—without a delineation of what those behaviors are

**Phase III**

**Search procedure.** The third phase search added three databases: MEDLINE for adults 19+, PsychInfo, and American Doctoral Dissertations. No other parameters were changed.

The search yielded another nine articles with relevance to the study. Included in this group were the studies by: (a) Isaac et al.,(2011), linking listening with safety; (b) Pill (2016), focusing on physicians in Beirut, with a mention of listening behaviors; (c) Chapin, Froats, and Hudspeth (2013), who used the Listening Styles Profile (LSP-16) and Watson's caring theory to highlight different listening styles; (d) Geist-Martin and Bell (2009), whose study focused on physicians in Costa Rica and discussed potentially relevant outcomes; (e) Davis et al. (2008), also referenced above because a definition of listening by the International Listening Association and a description of some listening behaviors were included; (f) Hall et al. (2015) whose study showed that accuracy of perception was teachable; (g) a study by Levy-Storms, Claver, Guttierez, and Curry

(2011) that included a quote from a nursing home patient related to a perception of the nurse aide's listening behavior; (h) Bavelas and Gerwing (2011), who documented listening behaviors, albeit in a different context than that of the proposed study; and (i) Desmond et al., 2014, whose study outcomes showed an increase in HCAHPS scores after nurses were trained in caring behaviors, including that of listening. These nine studies added to those from the previous searches as described above from Phases I and II to yield a total of 21 studies with some relevance to the study. A search through the studies' reference lists garnered still more documents, referenced throughout this dissertation.

**Listening concepts.** There were four listening concepts that had been highlighted by these studies.

***Link to safety.*** Listening and responding to patients' requests and concerns while expressing interest in the patients made patients feel safe by increasing their trust in the nurse, thus improving patient care and safety (Isaac et al., 2011). The most often reported errors in the Isaac et al. (2011) study stemmed from the lack of nurse listening.

***Careful listening.*** Geist-Martin and Bell (2009) explained the connection between communication and listening:

> Communication is authenticating when it recognizes the patient's role, agency, and responsibility in treatment. Through authenticating communication, the provider invites the patient to collaborate in the healing experience. To authenticate means to validate, endorse or establish as genuine. In this way, providers communicate in ways that authorize patients to become the authority or expert to author their own story. Authenticating occurs as a multidimensional

> philosophy and practice of (a) listening, (b) incorporating the words of the patient, (c) empathizing with the patient, (d) legitimating the patient's authority, and (e) organically coconstructing [*sic*] knowledge (p. 636).

Geist-Martin and Bell (2009) noted that what they specifically term *careful listening* supported and enacted the philosophy that saw the voice of the patient as important. They also suggested that one must go beyond passive listening to actively solicit, hear, understand, appreciate, and make sense of what the patient has said.

***Specific listening behaviors.*** Noticing patient cues and resisting the temptation to interrupt the patient while they are presenting their concerns were actions included by Pill (2016) as examples of listening skills employed by a member of the healthcare team. Levy-Storms et al. (2011) focused on behaviors by nurse's aides (NA) in nursing homes. In their study, they found that the NA would intentionally repeat back the last thing she heard the resident say so the resident knew that the NA was listening/paying attention. This tactic reflects what was discovered in nonhealthcare literature shown in Table 1.

Many of the behaviors shown in Table 1 have been supported in a study by Bavelas and Gerwing, (2011) in which they examined the key actions listeners used to collaborate with the speakers in a face-to-face interchange. Like in the studies represented above, their research was not done in a healthcare setting. Instead, they used convenience samples of students as actors from the university at which they taught. However, the behaviors have been included here as another indication of what can be found in the literature. Additionally, some behaviors were not on the previous list. Bavelas and Gerwing (2011) found the listeners (called addressees in the article) used NV expressions such as:

- Nodding/looking attentive
- Vocalizations, such as “m-hm,” and “yeah”
- Hand and facial gestures
    - Placing hand over mouth in appropriately shocking parts of the narrative
    - Wincing at appropriate times
    - Opening eyes wide to show surprise
    - Raised eyebrows
    - Smiling or stopping smiling as appropriate
- Not interrupting (helped by lack of distraction)

Verbal expressions of listening included:

- Paraphrasing
- Making appropriate verbal interjections (e.g., Oh my goodness!)
- Posing clarifying questions

Of interest in the study by Bavelas and Gerwing (2011) was that those who actively listened had a much better understanding of what was being said, based on how well they followed given instructions, than those assigned by the researchers to casually overhear the conversation. The researchers concluded that understanding, retention, and outcomes were improved when the listener had the ability to identify and clarify misunderstandings. They also found that distracted listening resulted in the same understanding and retention as those who merely overheard.

***Listening outcomes.*** According to Chapin et al. (2013), poor listening reflected a lack of empathy and led to an increase in malpractice suits. Alternatively, in the same

study the researchers found that effective listening, though not defined, was associated with an increase in (a) patient satisfaction, (b) emotional health, (c) functional and physical status, and (d) pain control. Geist-Martin and Bell (2009) also found positive benefits to perceived listening (in this study, listening done specifically by physicians). These benefits included (a) positive changes in patients' mental, emotional, and physical health and (b) a reduction in patient-perceived stress.

## Summary of Key Concepts in the Literature

Eklund (2014) posited that listening was one of the most problematic skills in communications, and as a society our skills have not been improving. Often that was because, as motivational writer Steven Covey (1989) has noted, "Most people do not listen with the intent to understand; they listen with the intent to reply" (p. 239). As noted above, literature was found highlighting the benefits of the act of listening within a patient-provider relationship (often focusing on physician listening). In studies focused on listening it has been shown that listening encouraged healing and caused no injury and was, in fact the foundation of an open, trusting relationship—something desired by all patients (Saini, 2016, para. 8). Wysong and Driver (2009) counted *good listener* as one of the attributes of a skilled nurse, along with being friendly, compassionate, caring, and kind. They found that the participants in their study believed the skilled nurse was one who knows how to listen, endorses patient complaints of distress, and responds with compassion as well as establishes a caring relationship through V and NV communication.

**Listening as Caring**

Much of the literature that mentioned listening mentioned listening as a subset of caring. It is the caring behaviors of nurses that lead patients to perceive the feeling of being cared for (Papastavrou et al., 2011). Caring behaviors have been defined as those acts, deportment, and gestures of professional nurses that conveyed concern, protection and safety, and consideration to patients (Greenhalgh, Vanhanen, & Kyngas, 1998) as they provided direct care (i.e., applied or face-to-face activities, versus work performed away from the patient; Cossette, Cote, Pepin, Ricare, & D'Aoust, 2006) and made themselves available (Clukey et al., 2009). One example came from the study by Isaac et al. (2011) in which they found that nurses made patients feel safe, "especially by listening to and responding to their questions and concerns with expressed interest, (which) can strengthen their trust, improving their care in the process" (p. 123).

According to Clukey et al. (2009), "tone of voice, the pace and force of actions taken, and the ability to engage in active listening were noted as nonverbal caring behaviors" (p. 77). Furthermore, Klagsburn (2001) stated that active listening was a way to reflect the crux of what the patient said which, in turn, could help patients to feel a real sense of being acknowledged and understood. Ultimately, "presence, listening and other caring behaviors" (Pipe et al., 2008, p. 247) have been shown to be important components of the patient experience. It is through touch or listening to patients share their experience that the depth of caring has been conveyed (Pipe et al., 2008).

But caring for the patient is about more than just the person in the bed; the care partner is integral to overall care. Listening to family members of patients has demonstrated that they, too, were cared for. Clukey et al. (2009) interviewed patient

family members who valued what they considered NV expressions of concern - also listed elsewhere as listening-related behaviors - such as eye contact, smiling, and the appropriate use of touch as an encouragement.

According to Suliman et al. (2009) and Chapin et al. (2013), caring was considered therapeutic and encompassed a host of actions and emotions, such as "respect, legitimacy, dignity, compassion, trust…. Empathy, understanding, and sensitivity" (Zugai et al., 2018, p. 419). A definition of empathy by Chapin et al. (2013) showed its link to effective listening: "Clinical empathy involves an ability to understand the patient's situation, perspective, and feelings; to communicate that understanding and check its accuracy; and to act on that understanding with the patient in a therapeutic way" (p. 3). Haley et al. (2017) have shown that working with nurses to improve their AL skills and enhance self-awareness can elevate their levels of empathy.

**Nurses as Communicators**

Of concern, and despite presumptions to the contrary, although nurses need to be skilled communicators, they are not necessarily innately so endowed (Clayton et al., 2014). Clayton et al. (2014) noted that communication must go beyond mere exchange of information; it also must (a) foster healing relationships, (b) respond to emotions, and (c) assist in decision-making and management of uncertainty if patient self-management was to be enabled. Objective data now exist showing that emotional appraisal of an experience was positively changed in response to perceiving AL by another using both V and NV behaviors (Kawamichi et al., 2015). On one hand, positive (and a trend towards) significant correlation has been observed between the use of NV listening behaviors and perceived communication skills (Greenstein et al., 2013). Verbal behaviors, on the other

hand, were, on average, stronger predictors of affect change than NV skills (Bodie et al., 2015). Recognizing AL behavior in oneself has been accompanied by a positive impression by the evaluator (Kawamichi et al., 2015). Active and perceived listening have been linked to patient "satisfaction" and communication (Wanzer et al., 2004; Fassaert et al., 2007) but people, in general, were often inaccurate in assessing their own capabilities and weaknesses (Grant, 2018) and nurses may not know how their behaviors have been perceived by their patients. However, if AL and nurse's self-awareness could be improved, empathic care could increase, and, in turn, patient-centered care could be bolstered (Haley et a., 2017).

**Lack of Listening**

At least two studies have shown that patients valued good listening skills even more than they did clinical competence (Person & Finch, 2009; Haroun, 2016). Often, however, it has been the times when patients felt disregarded that they have remembered. In the study by Schindler et al., (2017), Dominican patients shared their frustrations of having their opinions discounted or ignored, using the saying "no me hace caso," referring to their feelings of not feeling heard, a feeling that bothered and scared them. According to Clukey et al. (2009), being hasty or seeming rushed indicated to the patient that the nurse was too busy to listen. Additionally, not doing what the family asked indicated the nurse just did not listen (Wysong & Driver, 2009).

**Listening Behaviors**

However, listening behaviors that included non-nurses and were perceived by nonpatients can be found in the literature. Table 4 has updated Table 1 to include specific behaviors found during all three phases of the literature search.

## Outcomes of Listening

The concept of active listening has been discussed. Kliem (2009) noted that the goal of active listening was effective listening. Active listening has occurred when the listener has tried to fully grasp the speaker's meaning, whereas effective listening was the listener's attempt to understand the perspective of, and to empathize with the speaker (Kliem, 2009).

As has been noted, benefits of effective listening to the patient in a healthcare context have included (a) improved patient emotional and functional status, (b) improved adherence to the treatment plan, (c) improved recall of educational material regarding health status, and (d) improved quality of life in some settings (Davis et al., 2008). Positive effects of nurse listening also have included (a) increased patient satisfaction, (b) improved mental and emotional health, (c) improved functional and physiological status and health, and (d) increased pain control (Davis et al., 2008; Geist-Martin & Bell, 2009; Chapin et al., 2013), and (e) increased HCAHPS scores (Desmond et al., 2014). Although listening has been only one of several tools in the nurse's therapeutic tool chest, Haugan et al. (2016) reported that a "respecting, listening, supporting, understanding and acknowledging nurse–patient interaction is likely to enhance coping, and thus self-acceptance…and quality of life" (p. 795), as well as increase patient feelings of autonomy. Wanzer et al. (2004) found that, along with making introductions, nurse listening was one of the two most important behaviors for satisfaction with care. Although satisfaction is an outdated measure, it was the precursor to the modern measure of patient experience (Jenkinson, Coulter, Bruster, Richards, & Chandola, 2002) and therefore are discussed further.

Table 4

*Summary of Listening Behaviors for all Search Behaviors*

| Passive/Nonverbal (NV) | Active/Verbal (V) |
|---|---|
| Eye contact | Reads/taking notes |
| Affirmation sounds/vocalizations nodding/looking attentive | Reflecting feelings |
| Body position (e.g., leaning in) | Noticing NV and V signs |
| Use of comfortable silences | Encouraging clarification |
| Focus only on the speaker | Not interrupting |
| Mirroring behavior of others | Asking open-ended, clarifying questions |
| Facial expressions (e.g., smiling, wincing, showing surprise, raising eyebrows) | Read-back/paraphrasing/checking for understanding |
| Hand gestures (e.g., placing hand over mouth in appropriately shocking parts of the narrative) | Making appropriate verbal interjections |

**Satisfaction Versus Experience**

Because one focus of the proposed study has to do with the patient experience, and much of the literature mentioned patient satisfaction, it is important to be clear about the difference between the two. According to the Beryl Institute, patient satisfaction "refers to the level of contentment patients have for one or more aspects of care" (Jackson, 2018, para. 5) . Patient experience, in contrast, has been defined as "the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care" (www.theberylinstitute.org). Patient experience is a measure of (a) a focus on customized care, (b) the extent to which healthcare-related services have been adapted to meet the needs of the patient, and (c) to what degree patients were encouraged to be partners in their own care (Wolf, Niederhauser,

Marshburn, & LaVela, 2014)—a much broader goal and perspective than is satisfaction.

**Link to Safety**

Studies have linked patient safety and prevention of harm to nurse's caring behaviors with an emphasis on listening (Minick, 1995; Minick & Harvey, 2003; Isaac et al., 2011). To wit, although nurses viewed listening as the most important role within their caring function (Klagsburn, 2001), patients reported that the worst errors they experienced were due to the nurses' lack of listening (Isaac et al., 2011). When patients perceived that questioning their care would get them labeled as difficult (the opposite of being listened to) or that nurses expected patients to be submissive and reliant on them, they almost always remained silent even while putting their own safety at risk (Isaac et al., 2011). Also, as has been mentioned, patients who perceived their healthcare provider as possessing good bedside manners (of which listening is integral) were more likely to have had a safer post-hospital course as they followed treatment and instruction more carefully (Haroun, 2016). Other researchers reported that their study participants related bedside manner and listening skills to the feeling of being cared about—at least by their physicians (Wald & Temoshok, 2005; Person & Finch, 2009). They also endorsed the findings of improved health status, satisfaction, and compliance (Person & Finch, 2009). Geist-Martin and Bell (2009, p. 634) stated that even just having the perception of being heard lowered the stress patients felt and improved their overall health. Conversely, patient-perceived poor listening by their physicians often led to an increase in malpractice suits and patient deaths (Chapin et al., 2013).

## Target Population

The target population for this study was adults over 50 years of age. Although a diverse group, members of it shared certain demographics, experiences, and needs. The American Association of Retired Persons (AARP) last released a demographic snapshot of Americans aged 50 and over in 2014 (Anderson, 2014). This population was largely represented by female, married, white, retired or unemployed, and high school graduates with some college. With a median household income of $56,710, they had Medicare as their primary source of insurance and had purchased prescription drugs within the last month, largely to treat elevated blood pressure. Fifty-five percent believed they had complete or almost complete control of their health (see Appendix A: Target Population Demographics)

Myths about the realities of health and age-related changes in older Americans exist (American Psychological Association [APA], 2018). For example, the number of the oldest old living past 90 is increasing. As a matter of fact, the over-85 group has been growing faster than any other age demographic. Many were primary caretakers for their young grandchildren and women often lived in poverty. Understanding the realities helps the caregiver be more prepared to provide the best and least biased care. (Some relevant data published by the APA can be seen in Appendix B: Facts About Older Americans.)

Links between more education, higher income, and late-in-life cognitive health have been found (Zahodne, Stern, & Manly, 2014). The researchers have posited that such mediators as better access to higher-quality healthcare than their counterparts with less education, fewer exposures to stressors, and/or a greater incidence of participation in

cognitively-complex professions may serve as proxies for higher income (Zahodne et al., 2014).

The advantages of social ties and close personal relationships and the detrimental effects of loneliness in older adults was evident in the literature (Gerstorf et al., 2016; Martire & Helgeson, 2017; Rook & Charles, 2017). On the positive side, Gerstorf et al. (2016) found that maintaining social activity and having an active social life into later life was associated with (a) greater well-being, (b) slower decline, and (c) a later onset of what they term *terminal decline*—those precipitous declines in well-being that occur at the very last stages of late life. Martire and Helgeson (2017) argued that close relationships enjoyed by those with chronic illnesses positively influenced the trajectory of the illness as they aided in patient self-management of symptoms. Rook and Charles (2017) found that the older adult's emotionally satisfying social ties offered some protection from a decline in well-being and increase in physical limitations.

Alternatively, Gerstorf et al. (2016) showed that when social participation is reduced and such social participation goals as volunteering are lowered, the effect was one of mutual potentiation. Indeed, joining in social activities promoted feelings of competence as well as physical and mental health and functioning. Rook and Charles (2017) were also able to show negative consequences to the health of older adults when social ties were broken.

In the realm of the physical, Zahrt and Crum (2017) provided evidence of a link between the level of adults' perceived physical activity—in comparison to a peer group—and the likelihood of their mortality during a prescribed follow up period. The researchers concluded that adults' perception of their own health behavior, whether it

aligned with reality or not, played an important role in the creation of their future health outcomes.

## Gaps in the Literature

The findings by Chapin et al. (2013) related to outcomes due to poor physician listening discussed above may or may not apply to nurses, but the literature does not fully address the issue. Often listening by nurses is only mentioned in passing and as a subset of caring—patient perception of the behaviors accompanying the listening were not elucidated. As discussed above, Geist-Martin and Bell (2009) gave both a definition of careful listening and authenticating. However, neither the definition nor the philosophy explain how we know listening when we see it. As in most literature, it has been assumed the reader already had a working definition in mind (ILA, 2008).

Many of the studies discussed above focused on a population or a setting that differed from those of interest to this study. However, gaps in the literature include more than those of population and setting of interest. Often, the concept of listening was subsumed under general caring theory or interventions. Little information was found on effective listening behaviors in general, and those that did exist mostly focused on the sender, not the receiver. Underrepresented were communication skills used by nurses in all settings to facilitate greater emotional disclosure by patients and caregivers. The literature held little critical examination of the impact of patient perceptions of nurse-specific behaviors.

## Conclusion

Whereas listening is a universal human experience, it has remained subjective and the perception of it has differed by culture, context, and other variables. Of clinical

relevance has been that listening can be measured, and the skills associated with it taught to willing learners (Hall et al., 2015). Thus, this study's purpose was to discover, describe, interpret, and categorize patient perceptions of nurse listening behaviors and the outcomes they have on patient's experience in and beyond the acute care experience. Listening, or the perception of it, matters…to patients and to nurses. Listening with intent not only has been appreciated by the patient; it is also the right thing to do for patient well-being and safety.

# CHAPTER 3

# METHODS

In choosing a method that would best answer the study questions, several factors were considered. First was the lack of literature defining the phenomenon in the desired context and from the perspective of the patient. Second, no validated instrument was found to measure the phenomenon in a quantitative way. It became obvious that there was a need to elicit the lived experience of hospitalized patients at a foundational level.

## Choice of Methodology

A qualitative methodology, Interpretative Phenomenological Analysis (IPA), was employed for its ability to elicit rich, detailed, first-person accounts of the participants' recent hospital experiences. IPA has helped the researcher to interpret the way people have made meaning of their own experiences (Smith et al., 2012), which aligns well with King's focus on the role of perception in communication. Patients were able to share the nuances of their perceptions through face-to-face one-on-one interviews, the use of which has been supported by Heidegger's emphasis on the use of language as the mode through which the question of *being* could be disclosed (Korab-Karpowicz, n.d.).

Smith, Flowers, and Larkin (2012) defined IPA as an approach for qualitative, experiential, and psychological research that has been informed by concepts and debates from three key areas of philosophy of knowledge: (a) phenomenology, "a philosophical method of studying personal experience;" (b) hermeneutics, "the theory of interpretation;

and (c) idiography, "a focus on the particular" (p. 11). As a methodology, IPA has sought to capture specific experiences as experiences for specific people, the lived experience (Smith et al., 2012).

However, when researchers use IPA, although they attempt to access the participants' personal experiences on each participant's terms, there is an acknowledgment that the researchers do bring their own conceptions based on personal history to the encounter. This is certainly true of perceptions of listening; a very human experience. However, this reality allows the researcher to make sense of another person's world through a process of interpretative activity, described below (Smith, Jarman, & Osborn, 1999).

Thus, the term *interpretative phenomenological analysis* has been used to indicate the way in which the joint reflections of both participant and researcher have informed the final report (Osborn & Smith, 1998; Smith, Flowers, & Osborn, 1997); it is the interpretation of the activities people use to make their own meaning (Smith et al., 2012). The science, then, has depended on that lived experience (Smith et al., 2012). Ultimately, IPA reflects Heidegger's view that "phenomenological inquiry is from the outset an interpretative process" (Smith et al., p. 32), and it fulfills both idiographic and hermeneutic philosophies.

The link between IPA and King's theory is easily made. Each has been concerned not only with the individual's experience, but also with the individual's perception of that experience. In King's TGA the concepts for the personal system have included perception, space, and time; the concepts for the interpersonal system have encompassed interaction, communication, transaction, role, and stress, all the concepts

affected by listening and clarified using IPA methodology. Petiprin (2016) noted that such transactions as depicted in KTGA have represented a context in which the perceiver and that which is being perceived have encountered one another. Each person in the transaction was an active participant and was ultimately changed in the process of having had the experience. All the study's questions have focused on the patient perspective of a lived experience. Use of IPA will best help answer them.

## Study Participants

As Barbour (2001) has noted, "rather than aspiring to statistical generalisability or representativeness, qualitative research usually aims to reflect the diversity within a given population" (p. 1115). To attain that diversity, a hybrid process - also described by Barbour (2001]) - retaining elements of both convenience and purposive sampling was used to recruit participants.

### Sample Selection

As part of the convenience sample, most participants responded to a recruitment letter (Appendix C), or a request from someone familiar with the study and its inclusion criteria. However, because culture and ethnicity have been shown to play a role in perceptions (Franks, 2000; Meeuwesen, Van den Brink-Muinen, A., & Hofstede, G., 2009; Nedelcu, 2012), patients from diverse cultures and ethnicities were purposively recruited, again through colleagues familiar with the study. Men were also specifically sought to ensure possible perception differences based on sex. With the addition of purposive sampling, the final study cohort included patients from varied ethnicities as well as seven men to answer the questions of perception of nurse behaviors and outcomes from diverse contexts. Inclusion and exclusion criteria follow (See Appendix E).

**Inclusion criteria.** This study focused on adults over the age of 50 years who

- had experienced an in-patient hospital stay as a medical/surgical patient within the past 6 months;
- spoke English to the extent that they can converse fluently;
- were willing to participate and be audio recorded; and
- could tolerate participating in an interview that lasted 1.5 to 2 hours (although, ultimately, none lasted that long).

**Exclusion criteria.** Exclusion criteria included:

- age less than 50 years;
- had not been an inpatient on a medical or surgical unit within the past six months
- inability to communicate fluently (either in English or at all);
- inability to tolerate participating in a 1.5 to 2-hour interview;
- lack of interest in participating after initial contact; and/or
- diagnosis of disease such as Alzheimer's or dementia that would affect the memory and thus the interview process.

The focus on older adult patients (>50 years of age) was based on the more robust nature of their life experiences and having had more opportunities for reflection based on those life experiences compared with a population of either children or younger adults. The focus on patients who have been, but were not currently, hospitalized was based on the vulnerability felt by many admitted and previously independent patients, often reliant on nurses while hospitalized for meeting most of or all their needs (Corinsky et al., 2003). In this context nurse listening has had and does have a major impact on patient levels of

trust and comfort with the healthcare team and, ultimately, the outcome of their stay (Afaya et al., 2017). See also Appendices D (Participant Demographic Data Collection Sheet) and E (Prescreening Inclusion/Exclusion Script) for further details.

**Sample Size**

Although sample size is not known a priori in a qualitative study, enough potential patients were needed to fully inform the study by describing the depth of the phenomenon, leading to data saturation (determined throughout the iterative cycle of data collection and concurrent analysis). The original goal was to include patients from four hospitals representing differing catchment areas in Southern California. Sample size was to be determined when data redundancy was thought to have been reached and in accordance with the typical sample size used in current peer-reviewed, published phenomenological studies (e.g., approximately 20 participants).

**Setting**

Four main sites (acute care hospitals) were selected for participant recruitment by invitation at discharge. By design, participants were the ones to initiate the first contact. All four sites are acute care facilities in Southern California (see Appendix F: Original Recruitment Facility Demographics) and covered an area 100 miles east to west and 60 miles north to south.

**Nurse Demographics**

As the focus is on the behaviors of nurses who cared for the participants, an understanding of the California nursing workforce has been summarized. According to Spetz, Chu, Jura, and Miller, (2016), most California RNs at that time were white, married, females, although the addition of men to the profession has been accelerating.

Less than half had a bachelor's as their highest degree, although within the younger portion of the cohort that percentage was higher (over 60%). Most worked 33-40 hours per week (see Appendix G: California Nursing Workforce Demographics for details).

**Protection of Human Subjects**

Study approval was sought and received from the Institutional Review Boards (IRB) at all four original formal recruitment facilities discussed above. Two facilities expedited the study and two exempted it from the need for formal IRB approval because no research was performed on premises. As previously discussed, an informational recruitment letter (Appendix C) distributed by nursing management during patient discharge from these acute care hospitals was used to recruit the study sample from these facilities, although only two were relevant. Preliminary contact was initiated by the participant, by design. Having the patient be the initiator was designed to reduce any hint of coercion on my part, as was conducting the interview after discharge. All participants signed the informed consent after an explanation of each part with the options to ask questions or to delay in the interview. (See also Appendix H: Informed Consent.)

Although the interview questions were not deeply probing, they were of a nature with the potential to cause some distress if participants relived a painful inpatient interaction while recounting their hospital experience. To ensure each participant had options to deal with unforeseen stress, each was given a list of no-cost and low-cost mental health resources should they desire to access them (see Appendix I: No-cost and Low-cost Resources).

## Pilot Study

Before undertaking formal recruitment and interviewing, a pilot study was conducted with two volunteers, one male (PM), one female (JJ). Both reflected the population of interest in age and recent hospitalizations in acute care hospitals in Southern California. The semi-structured questionnaire (instrument) shown in Appendix J was used. Many of the themes found in the literature review were reflected in this pilot study; e.g., verbal and nonverbal cues, awareness of needs, caring, links to safety, and outcomes associated with both positive and negative listening encounters.

## Data Collection

As noted by Jacob and Furgerson (2012), qualitative researchers have sought to learn about the human experience through interviewing. In-depth individual interviewing has allowed for extemporaneity, flexibility, and sensitivity to individuals (Carter, Bryant-Lukosius, DeCenso, Blythe, & Neville, 2014). However, there are several ways in which to conduct an interview, even when that interview has been done one-on-one. Although considered the gold standard for qualitative research and, although allowing for maximum flexibility and guided by "lead" questions (Streubert & Carpenter, 2011), the open-ended/unstructured interview may cause the researcher—especially the novice researcher—to miss some salient points needed to fully understand the experience. Hence, because it still affords interview flexibility while maintaining focus, I used the semi-structured interview in this IPA-guided study. This technique uses a pre-determined and standardized set of questions to guide each interview, but is not rigid (Streubert & Carpenter, 2011).

The interviews were audio recorded, the contents of which were later transcribed verbatim by a vetted transcription company (Production Transcripts). This allowed me, a novice researcher, to focus on not just what the participant was saying, but *how* they were saying it. Recording impressions and perceptions as they occurred both aided in later recall and was an important tool for use during data analysis, as suggested by Streubert and Carpenter (2011).

Because the importance of my ability to convey a sense of active listening while asking about listening behaviors cannot be overstated, field notes were kept to a minimum during the interview process. However, the participants were advised of the possibility that such notes might be needed before the interview began to mitigate distraction and concern. Immediately after the interview was completed, I saved the audio recordings and listened to them as soon as possible afterward. In that way, notes could be made based on memory if the recording was somehow lacking or parts were unintelligible. In almost all the interviews this was not an issue.

**Data Collection Sources**

Primary sources, collected through interviews and observation and bolstered by field notes and post-hoc notes, provided the data for this study. Post-hoc notes were recorded immediately after the interview was completed where necessary, helping me with recall of both what was said and how it was said. Observation in terms of body language, pauses, tears, or laughter was helpful in interpreting and probing for more in-depth answers and richer data. Such observations were included in the written transcripts.

**Interview Site**

Because interviews were done after hospital discharge, and as a way of ensuring anonymity, safeguarding privacy, and giving the participant a place to speak freely, the site at which the phenomenon was experienced (the hospital) was different than the interview site. Because participants experienced nurse listening behaviors while a hospital inpatient, there were at least three reasons that were considered to preclude conducting the interviews in that setting. First, had interviews been conducted with inpatients, the participant may have been tired, experienced periods of unscheduled (or scheduled) interruption, been in pain, or had visitors, making the setting less than ideal for relaxation, focus, and reflection on the hospital experience. Additionally, the power differential (perceived or real) between nurse and patient would have conveyed the wrong message about participation in the study. A third reason, and perhaps one that could potentially bias the results, was the fact that the patient/participant would have been asked to report on the behaviors of the nurses currently caring for them.

Hence, data collection occurred from a few days to a few months (up to six) after discharge and was held in a place chosen in collaboration with the participants, usually at their home. The site was always one in which the participant was comfortable and that afforded quiet and both audio and visual privacy. Once there, the setting was made as quiet as possible (e.g., silencing the television) and the audio was temporarily halted for interruptions such as a phone ringing, dogs barking, entry into the area by another person, or children making noise.

**Interview Guide**

To establish context and build relationship, each participant was asked to share about his or her current life and health situation. Basic demographic information was collected as part of the interview process before the audio was begun. Participants was asked to disclose their age, ethnicity, culture to which they most related, marital status, total number of years of education, current or former profession or vocation, number of days spent as an inpatient during the most recent hospitalization, and number of days since being discharged from the most recent inpatient stay. Because, as mentioned above, gender socialization likely creates a different lens through which this phenomenon may be understood, both sexes were included, as were representatives from a variety of ethnicities who met inclusion criteria.

The participants were asked to recollect and consider their recent hospitalization. They then were asked to recall discrete instances of times in which they perceived the registered nurse (the nurse acting as their primary caregiver) had listened to them. Once they had evoked the memory, they were asked the question, "Can you describe the setting and what the nurse did that made you feel he or she was listening?" Prompts for this question included such requests as recalling the purpose of the nurse visit, the status of the patient, and other people in attendance. Conversely, they were asked to evoke a memory of at least one instance of a nurse acting as primary caregiver who they believed had not listened to them and to elaborate on what behaviors provoked the perception. Prompts such as, "Can you elaborate further?" "Were there any other signs, either verbal or nonverbal, that you can recall?" were added as needed. Many prompts were individualized to the specific conversation. A final question probed whether and how the

perceived listening or lack of it impacted their experience either in or beyond the hospital. Versions of the following questions were offered:

- "In what way did the nurse's listening affect your experience in and beyond the hospital, if at all?"
- "How did being listened to or not listened to make you feel?"
- "Did the experience affect your health?" (Appendix G).

## Data Analysis

Data analysis began concurrently with data collection, as is usual practice in qualitative research (Streubert & Carpenter, 2011). As this study was one of interpretative phenomenology, however, the focus was on the analysis of the data, with data being the interview narratives in which the study's participants sought to share and make sense of their lived experiences. In the end, however, the interpretation of that experience was the final product. Hence the (subjective) analytic process was made as transparent as possible. For this study, the steps suggested by Smith et al., (2012) were used as guideposts for analysis.

The transcripts were read at least four times: (a) once when comparing to the audio; (b) once as a completed document during which relevant content was highlighted; (c) a third time during which codes were added in the margins to place the highlighted content into categories, and (d) a fourth time when searching the text for appropriate quotes. The majority were read in their entirety at least one more time as the number of interviews grew to make comparisons across the cases; others were partially read after the fourth or fifth reading for details and nuance.

Once the themes were determined, they were connected by focusing on meaning, as opposed to chronology. This was done within each case, and subsequently between cases, leading to the development of super-ordinate themes under which related, subordinate themes were subsumed. The process focused on similarities as well as differences between concepts. Patterns were sought across cases, linking them together conceptually and theoretically, leading to the eventual identification of recurrent themes among the participants.

To enhance the credibility of the study, once themes were identified, I asked a third of the sample to review them for purposes of authentication. Professional peers were also given the opportunity to review for face value validation and alignment with the data, according to recommendations by Streubert and Carpenter (2011). A decision trail that included notes on decisions made was kept and is available for sharing when necessary to enhance auditability. By the final phase of data analysis, the phenomenon was thoroughly, if subjectively, described.

**Data Analysis Plan using Interpretive Phenomenological Analysis (IPA)**

An approach to qualitative, experiential and psychological research, IPA has been informed by concepts and debate from three key areas of philosophy of knowledge: (a) phenomenology (a philosophical method of studying personal experience), (b) hermeneutics (the theory of interpretation), and (c) idiography ("focus on the particular)" (Smith et al., 2012, p. 11). Instead of looking at experiences as having causal relationships or empirical justification, phenomenology is a subjective look at life (Internet Encyclopedia of Philosophy, n.d.). Because, upon reflection, our subjective experiences *appear* to us, they are called phenomena (Smith et al., 2012) and are, as far

as is possible, examined without a priori suppositions and preconceptions (Biemel & Spiegelberg, 2017). The idea was (and is) to get to the essence of what it means to be or to experience something. However, although the researcher attempts to access the participant's personal experience on the participant's terms, when one uses IPA, there is an acknowledgment that "access depends on and is complicated by the researcher's own conceptions…required in order to make sense of that other personal world through a process of interpretative activity" (Smith et al., 1999, p. 218-219). Science, then, has depended on "first order personal experience" (Smith et al., 2012, p. 15).

Ultimately, IPA has reflected Heidegger's view that "phenomenological inquiry is from the outset an interpretative process" (Smith et al., 2012, p. 32) and fulfills both idiographic and hermeneutic philosophies. This process or cycle, both iterative and inductive, gives guidance for analysis based on evidence-based strategies, including a final reflection on personal perceptions. The process is often conducted in six steps: (a) reading and re-reading of the data, (b) initial noting, (c) developing emergent themes, (d) searching for connections across emergent themes, (e) moving to the next case, and (f) looking for patterns across cases (Smith et al., 2012, p. 82-101).

**Reading and re-reading.** Each interview was transcribed verbatim as soon as possible after completion so that, while the discussion was still easily retrieved from the short-term memory, it could be read, re-read, and compared to the audio recording at least once to ensure accuracy and completeness. Quick turnaround transcription time was obtained (usually 48-72 hours) to help me recall nuanced answers or gestures.

Corrections were made, blanks were filled in, and most inaudible portions were able to be resurrected and included in the officially transcribed transcript where

necessary, based on my knowledge and recall of the discussion. This iterative process helped highlight patterns, repetitions, inconsistencies, and ironies, as suggested by Smith et al. (2012).

**Initial Noting**. The next step in the process involved the exploration of the content—of an experience within a context—for descriptive, linguistic, and conceptual nuggets mined from the transcript. As time was spent immersed in the data, patterns of repeated words, concepts, or phrases found in and between the individual texts was intentionally sought, as suggested by Magilvy and Thomas (2009). This examination resulted in detailed commentary drawn from the close and repetitive reading of the text. Beyond just what was said, the commentary was searched to find in what ways it reflected the interpreted meaning of the experience for the participant. This interpretation was based on both explicit and implicit participant expression in order to identify and make "sense of patterns of meaning in their account" (Smith et al., 2012, p. 83).

Descriptive aspects of the text reflected the participants' thoughts on "relationships, processes, places, events, values, and principles" (Smith et al., 2012, p. 83). For example, thoughts on what listening meant to patients—in this case, participants with personal experience with nurses in an inpatient setting who were interviewed for this study—included such comments as "focusing on what you're saying," "people looking at you in the eye and understand what you're saying," and "somebody focusing on what you're saying and not just listening with their ears but with their eye contact and…not speaking while you're talking. And then, asking for clarification to make sure that they heard you properly."

Linguistic analysis—the focus on the participant's specific uses of language (Smith et al., 2012)—revealed some assumptions and perceptions. Examples for the pilot study served as guideposts for the formal study. JJ, a new widow in her late 50s and one of two participants in the pilot study, shared that "If somebody has their back to me…I'm thinking they're not really fully focused on what I'm saying. It doesn't mean they couldn't be, but it's hard for me as the person talking to *know* that that person is really hearing what I'm saying." This has led me to surmise that there was, indeed, a way (or ways) that people "know" they are being listened to or heard. Use of words and phrases by the second participant, PM, a 59-year-old who had been hospitalized with a new cancer diagnosis, indicated which nurse behaviors he associated with listening. These included "mak[ing] things right," "thoroughness," having a "great attitude," "competence," and several examples of how he felt the nurse was aware of small details such as "closing the curtain properly," "straightening out the bed," being "on the ball," and being "polite." Although not listening behaviors per se, in PM's mind these things equated with the nurse taking initiative and anticipating needs, which he then related to listening.

Other criteria related to linguistic aspects of the text included "pronoun use, pauses, laughter, functional aspects of language, repetition, tone, [and] degree of fluency" (Smith et al., 2012, p. 88). One may have used pauses quite often as he or she sought just the right words to describe their meaning. Another might have used laughter, even in places that seemed incongruent with the text but reflected his or her personality. Hesitation forms were often used to some degree. Filler words such as "you know" and "um" were also often used while the storyteller sought to convey his or her experience.

Many of these forms were used throughout the narratives and were transcribed, verbatim, in the quotes highlighted in Chapter 4, Results.

Opportunities for conceptual annotation were realized, because the study dealt with (subjective) perceptions as evidenced by (objective) behaviors. Conceptual annotation was the first step to developing the emergent themes. For example, in the pilot study PM gave a description of one nurse who did not listen to him. He described the encounter as a series of behaviors. The transcription read, in part:

> I think she did…come in again and did the same thing but didn't touch the trash can, you know. She put on the gloves and she was touching other things and then she did something. But, you know, I had asked someone else, another RN, to explain to me why this happens, and, um, they said that they would take care of it and make sure it didn't happen again. So, it didn't [laughing].

The resultant conceptual take-away was that the nurse was nonresponsive, noncaring, focused on herself rather than the patient, had a dismissive attitude, was perceived as incompetent, was not sharp, gave no explanation, was not anticipatory (especially the second time doing the same thing), and was generally unaware. All these traits were culled from the participant's perception as evidenced by his story. By interpreting at this level, depth was added to the text and the real process of IPA began as a more probing spotlight was placed on the original text as narrated by the participant.

**Developing emergent themes**. To reduce the volume of detail in the text to a manageable size, I developed themes to reflect and illuminate the experiences of the participants, in a way that I believed was true to their perceptions. Although they also reflect the analyst's interpretation (Smith et al., 2012), themes capture and unify the

essence of the experience into a meaningful whole (DeSantis & Ugarriza, 2000) without losing the vital complexity of the content. These conceptual themes come to represent what was deemed important in the researcher's comments, which themselves reflected the original transcript, fulfilling one aspect of the hermeneutic circle in which the part was interpreted in context, that is, in relation to the whole, and vice versa (Smith et al., 2012).

**Searching for connections across emerging themes.** Once the themes were determined, an attempt was made to connect them, focusing on meaning as opposed to chronology or face value of the words. The process focused on similarities as well as differences between concepts, as they were found. Within each case, themes were clustered using the techniques of abstraction (an inductive method), and subsumption (a deductive method), leading to the development of super-ordinate themes. Contextual temporality was noted after being deliberately sought. One example from the formal study was the difference timing made in the ultimate patient experience; it was dependent on when during the hospital stay the patient had a nurse who listened versus one who did not.

**Moving to the next case**. The interviews were transcribed as soon as possible after completion. This usually occurred within 72 hours and depended on the workload of the transcription company and when the audio recording was received. Each transcription was then read at least once (more often twice) while the audio recording was being listened to. After that, each transcript was analyzed by itself, when the previous interview was still fresh in mind.

**Looking for patterns across cases**. Thematic development was done initially within each case, and then between cases, leading to the development of super-ordinate themes under which the related subordinate themes were subsumed. Patterns were sought across cases, linking them together conceptually and theoretically, leading to the eventual identification of recurrent themes among the participants. Most interesting were those themes that illuminated both a unique case as well as defined a higher order shared concept.

## Rigor

In a world of quantitative measurement, qualitative research is a newer and historically less accepted method of providing evidence. Although not equivalent to quantitative research in its rules and methodological stringency, both have the discovery of "plausible and credible outcome explanations" as shared goals (Morse, Barrett, Mayan, Olson, & Spiers, 2002, p. 14). Qualitative research still must be done in a way that supports the results, lest the study be of no perceived use. Focusing only on process rigor, however, puts the study at risk of missing threats to credibility until after it is too late to adjust the plan. Procedural (constructive) and analytic (post hoc) rigor was used to support the perceived trustworthiness of the study's findings because without rigor, research is not usable (Morse et al., 2002). It is important to note, however, that the inferences made of the data were what was important, not the data themselves (Maxwell, 1992). This was the premise upon which the following discussion on threats to credibility was based as well as the discussion on what was done to eliminate these threats.

**Procedural rigor**. Procedural rigor, also referred to as trustworthiness, refers to data collection techniques that were appropriate and detailed, and the idea of incorporating a reflexivity to reduce bias and a misrepresentation of the experience (Ryan, Coughlan, & Cronin, 2007). Often, rigor has been enhanced by using such evaluative criteria as credibility, transferability, and confirmability (discussed below).

***Identification of and procedures for managing personal biases.*** Every human being has experience with the concept of listening, both as they practice it and as they perceive it in others. Hence, it is important that a study's principal investigator has reflected on and documented personal preconceptions, assumptions, personal beliefs, and biases based on personal experience and knowledge of the literature, being careful and intentional not to interject bias while interviewing. To this end, the questions used were semi-structured (thus proactively diminishing biases), open-ended, and nonsuggestive, allowing the participant to paint their own picture of listening through personal experience.

Before the first consultation and to establish some face validity, the interview guide was vetted by research faculty using a questionnaire originally created by Onwuegbuzie, Leech, and Collins (2008) and adapted by Frels and Onwuegbuzie (2012). Sample questions in this questionnaire challenged me to consider such things as (a) personal perceptions of the participants and their nonverbal communication; (b) to what degree the findings aligned with any preconceptions I had; (c) how the interviews might have made an impact on the participants' self-perception; (d) ethical issues uncovered by the interviews, and similar reflections. Debriefing interviews with faculty were useful for

increasing legitimacy by also addressing threats to descriptive and interpretive validity (Frels & Onwuegbuzie, 2012).

After the first (recorded) interview, I reviewed the audio tape and sent it to both the research committee chair and the methodologist to identify any evidence of bias. No adjustments were deemed necessary.

**Analytical rigor.** In qualitative research, it is not content that is being analyzed, but data and emergent themes (Sargeant, 2012). Because rigor reflects the study's thoroughness, an audit trail was kept, aiding in the recall of decisions, actions, and the rationale behind decisions and actions. However, the checklists of analytic rigor did not take precedence over or become prescriptive of the gestalt of the research design and data analysis (Barbour, 2001).

In general, data were deconstructed into component parts (achieved by reading and rereading the interview transcripts), then placed into categories that best reflected the content's various themes. During the interpretation stage, categories or codes were compared to find emerging themes. When that was completed, the super-ordinate and subordinate themes were analyzed for inherent relationships and insights within the philosophical framework and in consideration of available evidence. It must be noted, however, that concurrent and cross-case analysis precluded these stages from occurring strictly sequentially.

**Auditability**

To give other researchers the chance to replicate this study, a detailed record of all methodological decisions (e.g., data sources, sampling decisions, and analytical procedures and their execution) was maintained (Cooney, 2011). This audit trail has

provided the documentation of potential bias and personal thoughts and feelings generated throughout the study.

## Trustworthiness

Like all investigators, I wanted the results of this study to be trusted. To ensure trustworthiness, deliberate steps were taken to authenticate the high standards to which the data collection was held (Davies & Logan, 2012). These steps included scrutiny and confirmation throughout the study and included a focus on credibility, dependability, confirmability, and transferability.

**Credibility.** Integrity and reliability are words that help describe the credibility desired in qualitative studies. Credibility refers to the extent to which the description has reflected the actual phenomenon under study (Ryan et al., 2007). Being the qualitative equivalent of a quantitative study's internal validity, the goal has been to make the study's findings a true representation of reality as perceived by the participants. In this study, the underlying premise was that validity refers to the inferences drawn from the data, not to the data themselves (Creswell & Miller, 2000) and that validity may be defined as "how accurately the account represents participants' realities of the social phenomena and is credible to them" (p. 124-125). As validity reflects contextuality (Maxwell, 1992), the results should ring true to the reader. Thus, to increase the chances that the findings accurately reflected the lived experiences of the participants, several measures were taken throughout the course of the study.

**Peer checking/debriefing.** One approach was to engage in both peer and member checking. Although most often used in studies based on a critical paradigm (Creswell & Miller, 2000), peer debriefing was used in this study to support the

credibility of the results because I was a novice researcher. Getting input from experts (e.g., the dissertation committee) served to confirm the legitimacy of the findings and speak to the choice of methodology and the operationalization of the process.

**Member checking.** As long ago as 1985, Lincoln and Guba described member checking as a most vital procedure for establishing credibility in a study. Even though this idea has not been universally embraced, in the quest for transparency and with an eye to enhancing this study's credibility in a variety of ways, member checking (or respondent validation, as it is also known) was used. However, it was done with the tacit understanding that my goals may not align with those of the respondent; i.e., an overview of the topic versus a focus on individual concerns (Barbour, 2001). Thus, this method was not heavily relied upon, but instead was one of several techniques used to convey a commitment to producing credible findings.

Asking the participants to corroborate the findings, member checking is akin to the readback employed in clinical settings to enhance safety; only the participant knows whether what was written reflects his or her reality. Thus, to accomplish this, both original data and my interpretations of those data were shared with eight of the study participants for corroboration and to confirm the credibility of the themes, categories, and overall narrative.

**Triangulation.** Another procedure that can be used to promote internal validity in a qualitative study is triangulation, the use of more than one method of data collection. This method is used to look at the study through the lens of the researcher and is reflective of a postpositivist paradigm (Creswell & Miller, 2000). To accomplish it, researchers generally use varied sources to reach convergence on the way to creating

themes or categories. These points of convergence are thought to underscore the credibility of the data. However, as in member checking, not all have agreed on its utility and reliability in achieving its stated purpose. Barbour, 2001, noted that whereas triangulation measures all interpretations against a singular fixed point, qualitative research, which is routinely done within a relativist paradigm, instead recognizes the equal validity of multiple views.

Nonetheless, two methods of triangulation were used in this study. The first of these was data source triangulation. In this study, listening to the lived experience of a variety of participants with varied demographic profiles helped create thematic convergence as similar themes emerged. Recruiting patients from more than one site and from within varied catchment areas where nurse demographics and culture may differ, was another way to produce a comprehensive view of patient perceptions of nurse listening behaviors.

The second method used was to triangulate across methods. Documentation of observations made during the interviews was considered another validating strategy. Observations were compared to the narrative to underscore the credibility of what was heard.

**Dependability**

Dependability (or auditability) reflects consistency, or stability, measured over time and in similar conditions (Davies & Logan, 2012), and is dependent upon the researcher providing enough information for the reader to determine the perceived dependability of both the study and the researcher (Ryan et al., 2007). The extent to which the results are dependable is predicated upon the study's credibility.

Triangulation, also discussed above, is just one way to add to the perception of a study's dependability (Streubert & Carpenter, 2011). An additional strategy to enhance dependability was to confront my potential biases in a reflective journal.

**Confirmability**

Considered a process norm by Streubert and Carpenter (2011), confirmability in qualitative research refers to the extent to which the study's results are replicable. Confirmability is provided when a researcher can clearly demonstrate how inferences and understandings have been reached (Ryan et al., 2007). To ensure that some as-yet-unknown future researcher could reasonably replicate this study, an audit trail was kept as described above. Though a future researcher's findings may differ, the process, at least, will be able to be replicated.

**Transferability**

Also conceived of as generality (Corbin & Strauss, 2015) or fittingness (Ryan et al., 2007), transferability refers to the extent to which a study's findings can be useful within different contexts or in populations that differ from those in the study. Although the geographic area whence the sample was drawn was less than 200 miles from east to west and less than 100 miles north to south within the same U.S. state, the transferability was increased by (a) recruiting from many sites representing varied catchment areas, (b) having a range of ages over 50, (c) including participants of both sexes, and (d) representing different ethnic or cultural backgrounds as much as possible given the constraints of the inclusion criteria (e.g., ability to fluently speak and understand the English language and self-referral to the study).

**Threats to Credibility.** Threats to credibility exist at every step in the process of IPA. Each section above has included a description of the efforts that were taken to mitigate these threats and to provide the one who reviews the research with a sense of the rigor and transparency with which the study was completed. In an easy-to-read visual, Table 5 lists the mitigation tactics that were used to thwart associated credibility threats.

## Data Management

### De-identification

To ensure anonymity, each participant was identified in all written or audio documentation with a name, chosen a priori by the participant, or with a number based on the chronology of when they were interviewed. The facilities represented by participants have been coded as facilities A through O (see Appendices C and D).

Table 5

*Employed Credibility Threat Mitigation Tactics*

| Threat to Credibility | Internal and External | Method of Evaluation |
|---|---|---|
| Descriptive Validity | Internal | Member checking<br>Audio recordings<br>Triangulation<br>Debriefing interviews |
| Researcher Bias | Internal/External | Peer checking<br>Member checking<br>Debriefing interviews |
| Reactivity | Internal | Triangulation<br>Debriefing interviews |
| Interpretive Validity | External | Member checking<br>Audit trail<br>Debriefing interviews |

*Note.* Adapted from Frels and Onwuegbuzie (2012, p. 9).

Each participant was identified in all written or recorded documentation with a name,

chosen a priori by the participant, or represented by participants are coded as facilities A through O (see Appendix K: Additional Facility Demographics, Parts A and B).

**Transcription**

Interviews were audio-taped for later transcription. A secure, professional transcription service vetted by Azusa Pacific University's IRB transcribed the audio recordings. Upon receipt of the transcription, I reviewed the written transcript while listening again to the audio recording to assure accuracy. Corrections or additions (e.g., audio that was unintelligible to the transcriptionist but that I understood) were made during the process. As promised to the participants, the audio recordings will be deleted from my computer upon conclusion of the study and publication of the findings to ensure participant and data confidentiality.

**Safekeeping**

Only participant family members present at the interviews and I knew the identity of the participants. Each participant was identified with a self-chosen pseudonym, and the electronic list documenting the same had been kept in a password-protected computer. The key to the association between participant name and code has been kept separately from documents that listed the pseudonym. Only I have had access to the electronic files, which have been maintained in a password- and biometrically-protected personal computer, and written interview data such as field notes, have been maintained separately from the code sheet. Printed data documents, such as interview transcriptions, have been kept in a double-locked area to which only I have had access. Audio recordings documented only the pseudonyms chosen before the interviews commenced. Computer files were backed up onto a password protected drive and saved in a secure

location removed from the computer. Data will be kept for three years, at which point they will be destroyed. No data were left accessible during transport and were sent securely if sent electronically.

## Conclusion

Nurse listening—or the perception of it—is important, both to the patient and to the organization providing the care. It has been measured by the U.S. government and has been aligned with improved patient outcomes and hospital reimbursement. No instrument has been found to measure these patient perceptions of nurse listening behaviors nor has literature been discovered that has been reflective of the proposed population or setting. Therefore, based on the dearth of literature on this subject, an interpretive phenomenological study was conducted to discover, describe, interpret, and categorize the lived experiences of adults who had been recently hospitalized as it related to the listening behaviors of their registered nurse primary care givers.

# CHAPTER 4

# RESULTS

The following chapter has highlighted the results of this qualitative study conducted using a Heideggerian interpretative phenomenological analysis methodology and guided by King's theory of goal attainment, specifically from the perspective or perception of the patient. Not only did the 23 participants elucidate nurse behaviors (both verbal and nonverbal, listening and nonlistening), they also identified ways in which those behaviors affected them (i.e., the meaning they placed on the behaviors). In the following sections, participant perceptions of various nurse behaviors have been listed by category (e.g., some combination of verbal, nonverbal, listening, and nonlistening behaviors) and then combined into superordinate themes for clarity and to reduce the volume of detail in the text to a manageable size.

## Setting

As discussed above, four main sites (as described in Appendix F) were selected for participant recruitment via letter of invitation on discharge. Two of the four sites (hospitals B and D) had such long delays getting the necessary IRB approvals—both attributed to on-site personnel issues—that data saturation had been reached by the time they were ready to distribute the recruitment letters. Hospital C distributed the recruitment letters, but no patients called. Of those four facilities, only hospital A was represented in the final analysis. Ultimately, data saturation was achieved through people

who had knowledge of the study with connections to patients who met the inclusion criteria. The added participants represented 11 additional (12 total) inpatient settings in four Southern California counties, including Los Angeles, San Bernardino, Ventura, and Orange. Extended portions of Los Angeles county were also added (e.g., the southernmost and more urban areas). As discussed above, the 11 additional facilities' demographics are highlighted in Appendix K. The relevant portion of Southern California which includes the locations of all 12 facilities represented by the study's participants extends a distance of 104 miles from the easternmost to the westernmost facility. The distance north to south is approximately 60 miles.

**Study Participant Demographics**

Table 5 has categorized the demographic makeup of this study's 23 participants. No participant declined to answer any of the demographic questions. Because any age over 90 was coded as 90, all ages of inclusion (i.e., 50-90) were represented in the sample. The key to the abbreviations for ethnicity and culture have been included at the bottom of the table. Again, hospitals B, C, and D were not represented by any of the participants. The reasons for this have been discussed below.

Table 5 has included, at its right, the hospital in which participants received all or some of their care. Even though it was not part of the formal demographic questionnaire, the hospital name was always mentioned. For an easy visual, and to get a sense of demographic representation, the data have been represented via the various pie charts included below. For details, see Appendix L, Participant Demographic Representation.

For clarity and ease of comprehension, some data identified in Appendix L (Participant Demographic Representation), were also depicted in the figures below.

Table 6

*Study Participants' Demographics*

| Name | Sex | Age | Ethnicity | Culture | Marital status | Education (yrs) | Profession | Days in hospital | Days since D/C | Reason for Hospitalization | Hospital |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Isabel | F | 56 | C | A | W | 16 | HR professional | 3 | 60 | Stroke | E |
| A.M. | F | 84 | C | A | D | 17 | RN (ret) | 14 | 180 | Shoulder/femur fx | A |
| Joseph | M | 56 | H | WH | W | 14 | Construction | 6 | 8 | Hip replacement | A |
| Nate | M | 61 | C | A | M | 14 | Firefighter | 3 | 56 | Revise hip replacemnt | G |
| Diane | F | 70 | C | A | D | 16 | Educator (ret) | 5 | 20 | UTI w/Blood | G |
| Neon | F | 62 | C | A | M | 12 | SAHM | 6 | 175 | Pelvic /spinal stabiliz. | G |
| Mickey | F | 63 | J | A | M | 16 | Graphic Designer | 2 | 13 | ORIF shoulder | G |
| Kitty | F | 61 | C | A | M | 17 | PA/sales manager | 2 | 169 | Hemi-thyroidectomy | H |
| Lily | F | 73 | C | A | M | 15 | HR professional | 5 | 161 | Benign Brain Tumor | F |
| Holly | F | 54 | C | A | M | 16 | HR professional | 2 | 16 | Infected Gallbladder | E |
| Bella | F | 72 | NA | A | W | 12 | Office support (ret) | 2 | 15 | Pacemaker placemt | I |
| Giovanni | M | 51 | H | A | D | 18 | Healthcare Admin | 6 | 176 | Pneumonia | A |
| Ref | M | 70 | C | A | D | 18.5 | Software Engineer | 3.5 | 164 | Intestinal bleeding | F |
| Bruce | M | 66 | C | A | M | 17 | Teacher | 14 | 159 | Full arrest | E |
| Island Grl | F | 55 | A | A | D | 14 | Resp Therapist | 4 | 171 | TAH | J |
| Karen | F | 68 | C | E | W | 31 | Clinical Ethicist | 19 | 171 | Acute pancreatitis Abdominal abscess | N |

Table 6, continued

| Name | Sex | Age | Ethnicity | Culture | Marital Status | Education | Profession | Days in Hospital | Days since D/C | Reason for Hospitalization | Hospital |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Arlene | F | 66 | C | A | S | 16 | RN | 3 | 14 | Sigmoid colectomy | E |
| Tarek | M | 50 | ME | ME/A | M | 16 | Sales Manager | 10 | 28 | Bowel resection: CA | K, M |
| Richard | M | 77 | C | A | M | 12 | Security work (ret) | 20 | 73 | Stroke | A |
| Jean | F | 62 | C | A | M | 12 | Waitress (ret) | 6 | 4 | Emerg spine surgery | G |
| Lottie | F | 74 | AA | A | S | 15.5 | Clerical/ Sec'tarial | 5 | 43 | Polyp removal | L |
| Carol | F | 66 | J | A | M | 16 | School teacher | 2.5 | 21 | Kidney removal: CA | O |
| Anita | F | 90 | H | M/A | W | 11 | Retired | 5 | 37 | Severe anemia | A |

*Note.* Ethnicity: C - Caucasian, H - Hispanic, NA - Native American, J - Jewish, A - Asian, ME - Middle Eastern, AA - African American Culture: A - American, WH - White Hispanic, E - European, ME/A - Middle Eastern/American hybrid, M/A - Mexican/ American hybrid.

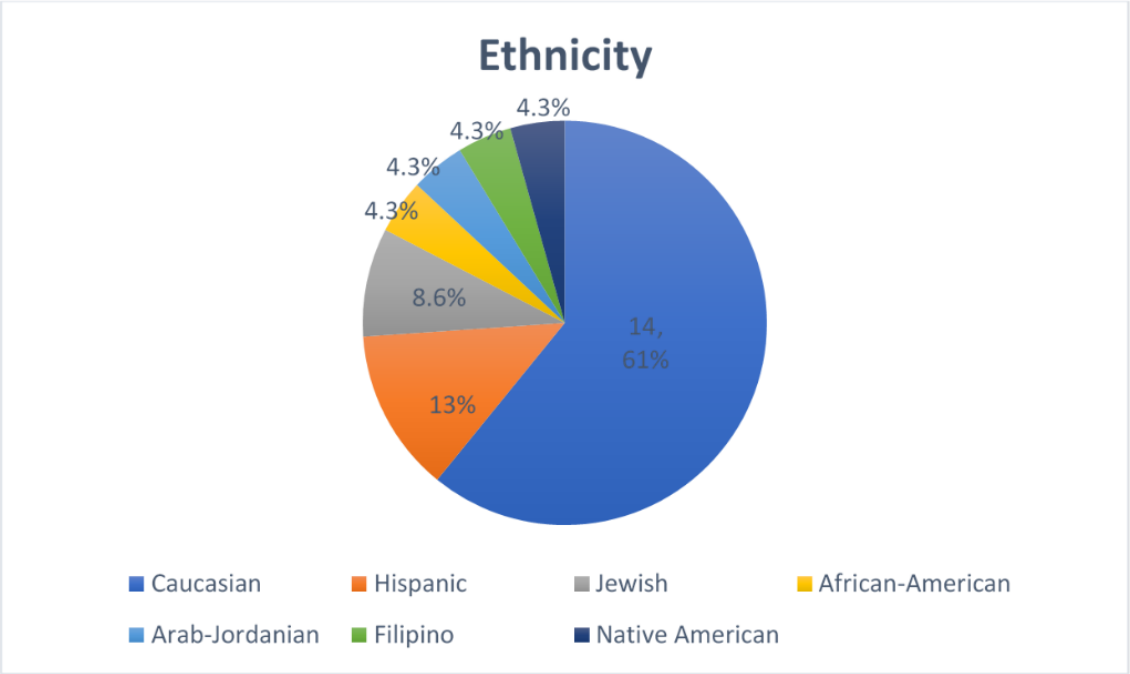
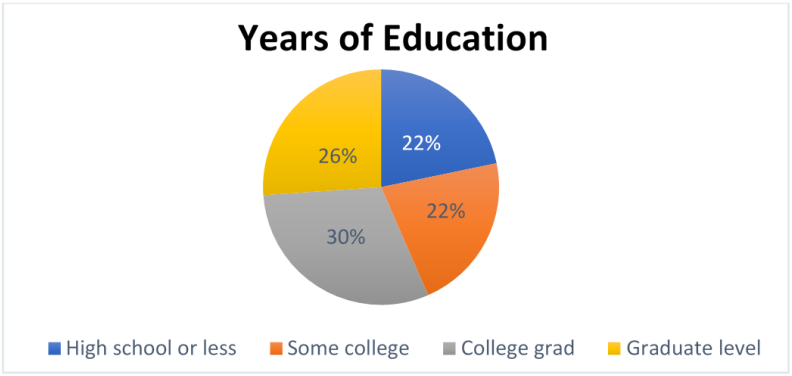


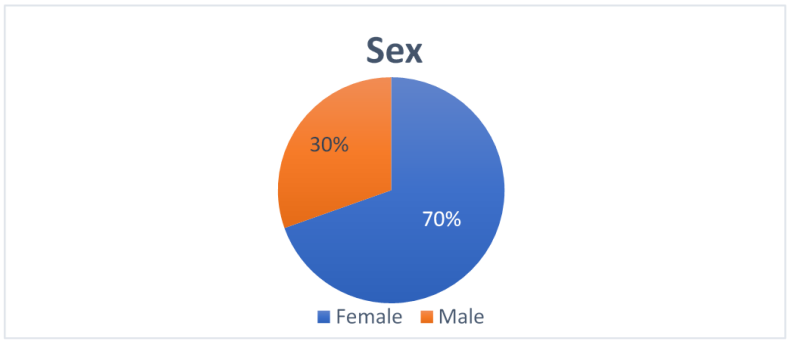

*Figure 3.* Participant ethnicity.

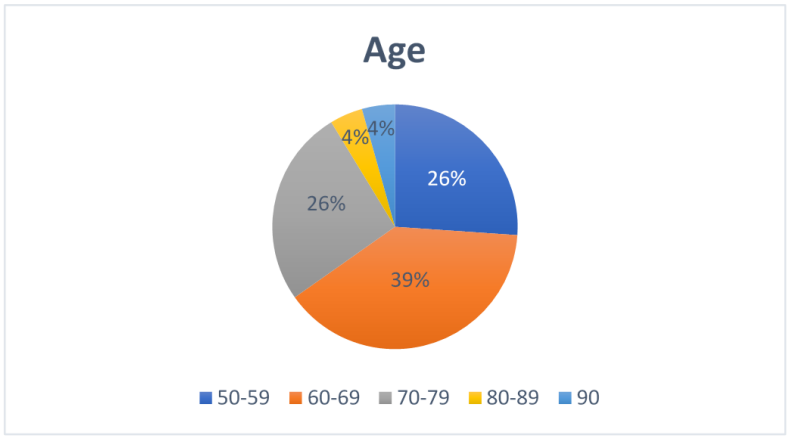
**Member Checking**

As described in the methods section, participants (members) were asked to review the codes and themes to validate that they reflect their lived experience. In this way the study's credibility would be enhanced. Every participant who reviewed the codes and themes agreed that they accurately reflected their personal experience. Their comments supported the way their experience was depicted. Comments included:

- The results are right on
- The themes seem appropriate and the outcomes make sense
- Looks like my experience in almost every category for the night shift nurse
- Right on
- Makes sense to me and does reflect my reality



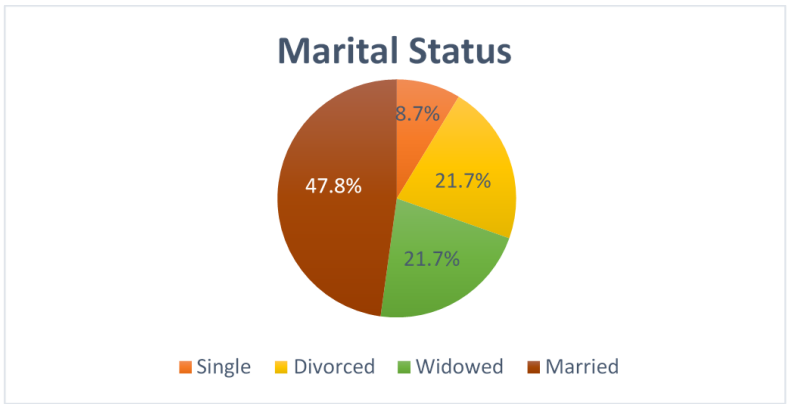




*Figure 4.* Participant sex, age, marital status, education.

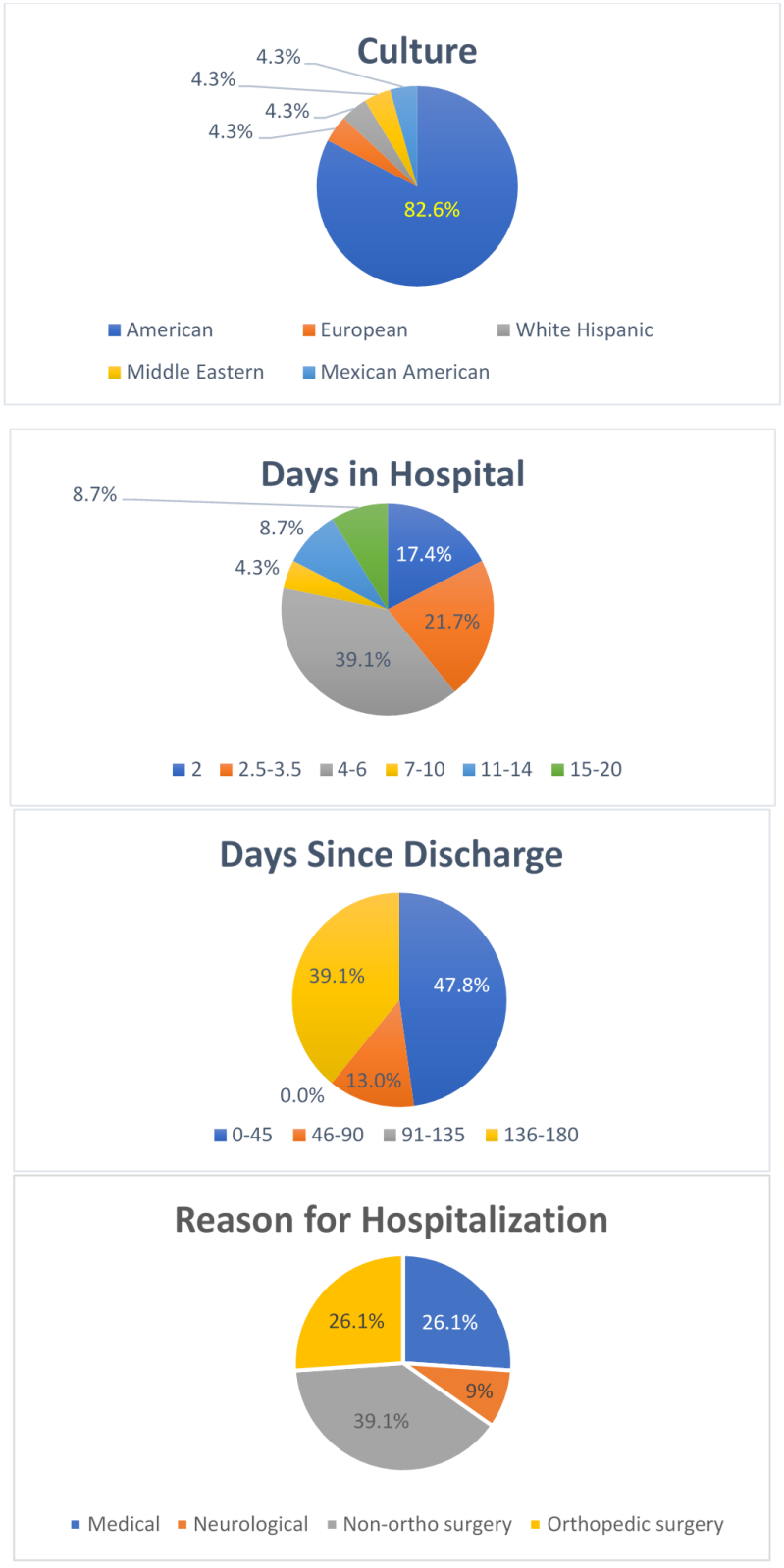



*Figure 5.* Participant length of stay, culture, days since discharge, and reason for hospitalization.

- Looks great
- Very detailed and correct
- Makes my day. Glad something good came out of these surgeries for someone
- I agree with what you put in both columns
- If I had not been part of the "survey" I would have easily understood the questions and results
- They made sense to me

The goal of the study was to answer the following research questions from the patient perspective: (a) which nurse behaviors implied that listening has occurred, and (1.1) what emergent themes arose from the data; (b) which nurse behaviors implied that listening has not occurred, and (2.1) what emergent themes arose from the data; (c) how did the perception of both listening and nonlistening affect the patient, both in and beyond the hospital, and (3.1) what emergent themes arose from the data; and (d) what advice do the participants have for nurses as it relates to listening? (Appendix D: Participant Demographic Data Collection Sheet). The findings related to each question are presented.

## Research Question 1:

## Which Nurse Behaviors Implied Listening Had Occurred and What Were the Emergent Themes?

In descending order by number of times mentioned by participants, both verbal and nonverbal behaviors described by participants as listening behaviors have been shown below in Table 7. Percentages are rounded for clarity. It should be noted that the

codes were only given to participant words or phrases that clearly described the concept. If I had chosen to code more subjectively (e.g., if participant wording had been inferred to a greater degree), many of the codes would have been shown to be endorsed by more participants.

To make the data more meaningful, once the codes were identified, they were placed within themes. The emergent themes reflect the way the patients perceived the listening behaviors (Table 8). These included:

- Making a Connection
- Putting the Patient at Ease
- Ensuring Safe Care

The themes are discussed with quotes from the participant interviews to define each code within it and to help convey a sense of the reasoning behind the thematic groupings. Each theme will reflect both verbal and nonverbal behaviors that comprise it.

**Making a Connection**

Contained in this category were many behaviors addressed by a large contingent (up to 70%) of participants. It is this category that included the behaviors that were most agreed upon in any category: eye contact or attentiveness, considered a nonverbal listening behavior. As shown in Table 8, there are 17 codes that comprise the theme of Making a Connection. These observations were made manifest through many participant statements.

Eye contact/attentiveness was the one (or two, if they were not viewed as interchangeable) behavior(s) that 70% of the participants agreed showed listening. Eye

Table 7

*Patient-identified Listening Behaviors*

| | # Who Identified | % |
|---|---|---|
| Verbal | | |
| Asking questions/personalizing care | 13 | 57 |
| Making a connection/taking interest in the patient | 8 | 35 |
| Answering questions | 7 | 30 |
| Prompting patient to share (including emotionally) | 6 | 23 |
| Speaking TO the patient (versus "at" or facing away) | 6 | 23 |
| Repeating back what patient said | 5 | 22 |
| Assuring smooth transitions/passing on information | 4 | 17 |
| Being polite/nice | 3 | 13 |
| Narrating care/Explaining things | 3 | 13 |
| Anticipating questions/needs | 3 | 13 |
| Hearing but overriding patient desires in patient's best interest for safety | 3 | 13 |
| Asking whether interventions worked | 2 | 9 |
| Encouragement/Reassurance | 2 | 9 |
| Including family in discussions | 2 | 9 |
| Not complaining about being called | 2 | 9 |
| Not interrupting | 1 | 4 |
| Talking to the patient BEFORE doing the task | 1 | 4 |
| Repeating information to ensure understanding | 1 | 4 |
| Nonverbal | | |
| Eye contact/Attentiveness | 16 | 70 |
| Follow through/Action/Timely responses | 14 | 60 |
| Body language (e.g., posture, hustle, sitting, leaning in)—note: 4/23 specifically mentioned sitting, which they felt was only needed 1x | 11 | 48 |
| Anticipatory/proactive as to needs and patient status | 11 | 48 |
| Caring/Empathetic/Going the extra step | 10 | 44 |
| Stopping doing other things | 9 | 39 |
| Undistracted focus on speaker/Presence | 9 | 39 |
| Understanding individual preferences | 6 | 26 |
| Giving help/assistance when needed/asked | 5 | 22 |
| Noticing patient body language/cues | 5 | 22 |
| Trying to understand patient perspective | 4 | 17 |
| Not rushing to get out/Spending time with patient | 4 | 17 |
| Believing what the patient says | 4 | 17 |
| Taking notes on what the patient says | 4 | 17 |
| Physical proximity to the patient | 3 | 13 |
| Therapeutic touch | 3 | 13 |
| Taking direction from the patient | 3 | 13 |
| Silence (use of) | 3 | 13 |
| Calm demeanor | 2 | 9 |
| Nonverbal affirmations (e.g., mm-hmmm, nodding) | 1 | 4 |
| Taking nothing for granted | 1 | 4 |

Table 8

*Patient-identified Listening Behaviors with Themes*

| Verbal | Nonverbal |
|---|---|
| **Making a Connection** | |
| • Asking questions/Personalizing care (56.5%) | • Eye contact/Attentiveness (70%) |
| • Making a connection/Taking interest (34.7%) | • Body language (47.8%) |
| • Prompting patient to share (26%) | • Stop doing other things (39%) |
| • Speaking TO the patient (26%) | • Undistracted focus on speaker/Presence (39%) |
| • Being polite and nice | • Understanding individual preferences (26%) |
| • Not interrupting | • Trying to understand patient perspective |
| • Talking to the patient BEFORE doing the task | • Proximity to patient |
| | • Silence (use of) |
| | • Vocalizations/nodding |
| **Putting the Patient at Ease** | |
| • Narrating care/Explaining | • Follow through/Action/Timely responses (60.1%) |
| • Anticipating questions/needs | • Anticipatory/Proactive regarding needs/status (47.8%) |
| • Encouragement/Reassurance | • Caring/Empathy/Going the extra step (43.5%) |
| • Including family in discussions | • Not rushing to get out/Spending time |
| • Not complaining about being called | • Therapeutic touch (for assurance) |
| | • Calm demeanor |
| **Ensuring Safe Care** | |
| • Answering questions/Explaining (30%) | • Giving help/Assisting when needed/asked |
| • Repeating back | • Noticing patient body language/cues |
| • Assuring smooth transition/Passing on info | • Believing what the patient says (this could be placed under more than one theme) |
| • Hearing but overriding patient desires for safety reasons | • Taking notes on what is being said |
| • Asking if interventions worked | • Taking direction from the patient |
| • Repeating information to ensure understanding | • Taking nothing for granted |

contact was often linked with other behaviors, as in the case of Isabel, a 56-year-old widowed, Caucasian, human resources (HR) professional who had just had a stroke. When asked what came to her mind when she heard or experienced the word "listen" or "listening" and its associated behaviors she stated,

> Probably somebody paying you respect that they're listening to what you have to say. They're taking it in. [The behaviors that showed listening would be] eye contact, the person engaging in the conversation, they're maybe repeating back what you've told them, so that they get it right…. I think the big thing is…eye contact. You know…her focus. She focused her attention solely on me. She would ask me how I was feeling, or did I need anything before she would leave the room. She would help me if I needed her to…. [She] asked me if I wanted food [but] I felt nauseous…but later she would prompt me again…[asking] specifically what I preferred.

These additional behaviors were also some of those placed under the theme of Making a Connection: (a) prompting the patient to share, (b) understanding individual preferences, (c) undistracted focus on the speaker, and (d) asking questions. They highlighted the personalization of care and the attempt by the nurse to make a human connection with the patient. Nate, a 61-year-old married Caucasian firefighter who had recently had a hip replacement agreed. When asked what the nurse did specifically that made him believe she had listened to him, he stated, "Just looking into my eyes and listen[ing] to every word I said."

At this juncture, it is helpful to note that some participants (especially males) had a difficult time linking listening with specific behaviors. They just "knew" when the

nurse was listening to them, defining "listening" with other forms of the word "listen." It took prompts and additional questions to get them to the place where they could identify the specific behaviors; how they knew the nurse was listening.

Joseph, a 56-year-old widowed, Hispanic, construction worker just discharged from the hospital after having had a hip replacement also linked listening with eye contact: "Her eyes came to me…in a patient/nurse way…. I had her vision. She wasn't doing something else. She would stop what she was doing…she just looked at me in a caring way." He was the first to identify undivided attention as the nurse intentionally stopping doing other things to focus on the patient. Diane, a 70-year-old divorced Caucasian now-retired educator agreed. She says she "knew he was listening because he stopped everything…."

This attentiveness was echoed by Neon, a 62-year-old married Caucasian stay-at-home mom with multiple recent hospitalizations for spinal surgeries. She loved nurse Joe and was always delighted when he was assigned to her care, as she was often back at the same hospital. She shared:

> He was there without being on the computer constantly…. He was quiet and—I mean he was like looking at me straight in the eye and watching me. And then more—I didn't realize until after the fact he was watching my body language. And I didn't realize how much I was clenching my fist. I was ready to like punch somebody. He recognized it and addressed it.

Island Girl, a 55-year-old divorced Filipina working in healthcare noted that, even though her nurses were busy, "they stopped and listened and sat down—they were going, 'I have time to sit with you'…and then we had a chat." When asked about the sitting, she

clarified that the nurse only needed to sit the one time, that that was enough. Giovanni, a 51-year-old healthcare worker agreed. One time to start the connection was enough. All the participants knew the nurses were busy and did not want to burden them unduly.

Holly, a 54-year-old married Caucasian HR professional summed it up by defining listening this way:

> In general, it's giving a person your full attention, it's the eye contact, it's the body language, it's the whole connection to show them not just that you hear but to also show them that you are taking an interest in what they have to say.

She describes her admission to the hospital from the urgent care via the observation area to surgery. In this description it was clear to see that a connection was made, leading her to feeling cared for and having a sense that the care was personalized:

> I was greeted and met by three nurses who were expecting me, who brought me into my room, who were very quick to introduce themselves and tell me exactly who they were and what they would be doing. [They were] very attentive to getting me set up and getting to know me actually, [and] took some time to ask a few questions just so that they knew who I was. And, I don't know, there was just something about that reception, if you will, that made me feel cared for. I guess that's the best way to put it. I wasn't just another person coming to the floor. That they were expecting me…that was kind of neat.

Island Girl had a very specific "quirk" that, were it not addressed in a personal way, would have made her recovery harder. She conveyed the way in which the nurses personalized her care by catering to a distinct preference she had.

> I had to drink water from a glass…I know I'm weird, but I have to have water from a glass bottle. It's just when I got sick, I just couldn't drink—regular water gave me heartburn, it just is weird. So, they would buy me big bottles of VOSS water that were glass and they would put [them] in a refrigerator.

Mickey, a 63-year-old married Jewish-American entrepreneur who had just had orthopedic surgery, shared an episode during which the nurse also catered to her individual preference, which she equated with the nurse having listened. After arriving late in the day to the patient care unit, the default lunch tray she had not ordered was delivered. Says Mickey:

> It was a weird, spicy, curry, nothing-like-I'd-ever-seen. I couldn't smell it and I couldn't eat it. And so, the nurse got on the phone and she called [after] I told her what was going on. She goes, "You can't eat this." And she called down to the cafeteria and had just a regular— "What do you want?" I said, "Just a sandwich is fine" or something…. And she ordered it for me and they brought it. So, somebody directly listened to me when I asked.

As simple as this action was, it was seen by the patient as an act of listening. And it was appreciated—and remembered.

Simple gestures that helped make a connection were also conveyed by both Carol and Anita. In the case of Carol, a 66-year-old married Jewish American now-retired school teacher admitted for newly-diagnosed kidney cancer, that simple gesture was a hug from the nurse—and prayer. For Anita, a 90-year-old widowed Hispanic retired secretary with severe anemia, that gesture, and the thing she most ascribed to listening, was the laughing and chatting about everyday occurrences with her nurses. According to

Anita, she and her nurse "had a lot of laughs. They would talk to me. They would turn. They were always busy, but we talked about gardening and things we did at home." Ref, a 70-year-old divorced Caucasian software engineer, used the term "human interactions" to define listening. These interactions helped make a connection with the patient and were ultimately perceived as listening.

Karen, a 68-year-old widowed Caucasian nurse (RN) described listening as "presence." She also mentioned connection and described knowing that the nurses were listening to her this way:

> She always came into my room to just check on me and say hello and it was [by] her mannerism and her eye contact that I knew that we were making a connection and whatever I was saying to her, she was actually listening to me. She pulled the chair over and sat down, she spoke to me in a very compassionate tone using my first name and I think it was really the eye contact that I knew that she was listening to me much more than head nodding or anything else; it was definitely maintaining eye contact. She then asked refined questions. As an example, whatever I would say, she would come back and say, "Here's what I heard you say, is that correct?" [When she did tasks], it was talking to me first, not doing tasks associated with conversation…. It was not juggling two actions at the same time.

Kitty, a 61-year-old married Caucasian former physician's assistant and an RN before that, was very clear, if a bit cynical, in contrasting the behaviors of nurses who listened with the behaviors of those who clearly did not. In describing the listener, Kitty spoke of that nurse's body language and how she perceived it.

> She moved quickly and when you asked for something, you could tell that she cared [or pretended to care even if she didn't]. She cared about what I was saying and went and followed through on it. It wasn't just, "Yes, of course. Yes, of course." She went and got an order and came back with the drug, you know, within a few minutes. So, it wasn't—that was the difference of action with nonverbal cues of, "OK, I get it," and the other person with the slow moving, "I've got things to do. You know, I'm the only nurse here tonight."

**Putting the Patient at Ease**

The second set of behaviors helped put the patient at ease. Kitty's story, above, highlighted the connection of listening to caring. As in the literature described in Chapter 2, this was not an unusual finding. This characteristic seemed to put the patient at ease.

Joseph equated listening with caring multiple times during his interview. Almost half the sample (43.5%) agreed. If one cared, he or she will listen. Caring was a precursor to listening. He said:

> To me, it's a matter of how much a person cares while in the hospital, and how much the person cares for you is how much they'll listen…. Listening is just, it's how much a person really wants to get to know you, how much [he/she] cares about a conversation…. She walked in and introduced herself…. We got to know each other a little more as time allotted…we found out we had a few things in common, which kind of helped us to understand each other more.

Carol, when asked what made her believe the nurses were listening, brought up other behaviors in this category. In the following scenario, she touched on anticipating needs, therapeutic touch, caring, being proactive, and eye contact again. During the

interview she became tearful thinking about both the positive and negative aspects of her care (at two different facilities). Carol gushed:

> They would give me hugs. They…prayed over me…. Whatever I needed I would get from them. Kim would take my hand and there was the touching…. I think it was caring. I think it was they cared about what they did. And they looked at you. I think listening happens first and then the touching and the caring and the understanding comes after. Because, I cried a lot there too [said as she was crying in the interview]. They always made sure I wasn't in pain. They gave me my meds on time. They, if I didn't ask for it, they were there every hour to [see whether] I needed it, you know, if I wasn't [not] asking for a reason; that it was that I didn't [actually] need it. [They were] proactive.

Already briefly mentioned, follow-through (and action and timely responses) were endorsed by over 60% of participants as foundational to listening. Island Girl described these nurse behaviors as those that let her know listening was occurring:

> Eye contact, empathy, and they said, "Don't worry, we're going to take care of this." I didn't wait an hour; if I had to wait an hour then I'm thinking, "They're not listening to me." But, you know, a quick response and then…

She also mentioned the reassurance given her by the nurses when they did something as low tech as rubbing her hand: "I'm a touchy person anyway so if they give me some kind of support, by, 'It's OK, [name], that's okay, we're going to get right to it…. Reassuring is a good word for it." She shared that "It was a scary moment for me…until we got the biopsy back, and just the way they were checking, making sure I was okay emotionally" was reassuring. "They asked me how I was feeling inside, like, 'I

know you're scared, I know you're—but you're strong, you're going to get through this; we're praying for you. That always helped." She also mentioned the nonverbal vocalizations many adults used (e.g., mm-hmmm) as being effective and "looking at you, not with their back turned to you. They always looked towards me and nodded their head as I was talking." These last several behaviors have been coded under the third theme, Making a Connection, but as with much of this and most of the other narratives, sentiments were linked.

Four of the 23 participants specifically linked listening and caring to "spending time" or "not rushing to get out.' Jean, a 62-year-old married Caucasian retired waitress recently admitted for emergency spine surgery compared the listening behaviors of her nurse, Anthony, with others she has had in the past.

> He was so caring and right-on. He knew me better than anybody else…. He told me he won some award and I can see why because he was on top of what [I] was going through. So, he gave me some advice, which usually nurses don't do. They come in, I've seen, do their job and leave. Go on the computer, leave. He spent the time, this time, to give me security.

Kitty, who has a history of reacting poorly to anesthesia and was in for surgery on her thyroid, shared a scenario in which she was fearful of vomiting after surgery but had a nurse who took time and listened: The nurse…

> …definitely listened because when I started getting nauseous, she immediately checked the orders, [and when the pill she gave me] didn't work, she got me an IV for that. I felt good after I knew she was doing something about it…. She was nice…. She seemed like she wasn't hurrying….

Mickey had a little different experience. Although she felt her nurse was paying attention, she also noticed that "she was very harried." Her interpretation was her belief that the nurse was overworked. However, as perceived by Mickey, "She was rushing, but she wasn't rushing to get out. She was just rushing to get everything done, and she did take the time in the beginning and really asked me if there was anything else I need."

Mickey also noticed: The nurse "stopped and took the time" even when there wasn't anything Mickey needed. Carol explained the phenomenon this way: "Whatever I said, sometimes she repeated back to me. And she was just there. I never felt like I was intruding on her time. She always had a smile. Always positive." Both Mickey and Carol acknowledged the nurses' patient loads, and both tried to be nondemanding, but they appreciated the perception that, at least for the moments they had the nurse with them, they felt like the nurse's only patient. Not rushing links to proactivity and calmness, which Neon described this way:

> Nothing made him mad…. When I was in excruciating pain, he would ration [sic] to me why, "Okay, what is going on? Okay, we need to stay ahead of this." And so, he was proactive by getting on the phone to the doctor, not waiting two or three hours for the doc; he was right on it. So, in his calming voice he was able to calm me down, which most nurses couldn't do when I was in there.

This proactivity or anticipating the message was appreciated by Isabel, who could not adequately express her fears and needs due to her stroke. Said Isabel, "She was trying to anticipate what I was trying to get to her and I would maybe physically gesture…. I was able to communicate a little bit to say, you know, 'Do you think I'm going to stay this way?' That was my one fear, you know…am I going to get better." Isabel added,

"She seemed like she had my care at the forefront. I felt very comfortable with her. She seemed very competent." And, what gave Isabel the most confidence in her: "She would explain a lot of what she was actually doing whenever she was in the room and why she was doing it…and then would also answer my questions…" The narrating of care helped alleviate the fears patients may have had, especially those patients who could not physically express those fears.

Tarek, a 50-year-old married Arab-American service manager with a new cancer diagnosis and recent surgery appreciated the same behavior, equating it with listening. Highlighting codes from more than one theme in his narrative he explained, speaking of the nurses, "…they were right next to you asking you if you needed anything, [and they gave me] eye contact." He said that their "body language is friendly" and that "they were telling me what they were doing…. When we're having conversations, and when they're asking me, they're not on the computer." This narrative speaks to attentiveness, narrating care, body language, eye contact, and the idea of friendliness. Tarek also perceived the hustle of his nurse as efficiency, not rushing to get out, because the nurse kept Tarek informed throughout the shift and always kept his promises.

Along with Tarek, Lily, a 73-year-old married Caucasian HR professional with emergency surgery to remove a large brain tumor, commented on the nurse keeping the family informed/including them in the conversation.

> The nurse…was very informative about where I was, what I was doing, what they were going to do, why I was there and if I needed this or that—there were people that she said I could speak with or ask. And, of course, she was speaking to my daughter as well…. She tried to be as informative and as open as she could. My

daughter did ask her some questions and she answered, so I think she was listening.

**Ensuring Safe Care**

The third and final theme under Listening Behaviors was entitled Ensuring Safe Care because of the way in which the behaviors often forestalled error. According to the Institute for Healthcare Improvement (IHI), "a growing body of research suggests that the lack of productive communication between patients and caregivers contributes to ineffective or inappropriate care, or even fatal errors" (2018, para. 2). Hence, these behaviors have helped ensure clarity and understanding, and assured the patient that their self-knowledge was not dismissed. The most oft-endorsed behavior under this theme was answering questions/explaining. Richard, a 77-year-old married Caucasian retired security guard said: "The nurses were always—you know, I knew they had to go on to the next one [patient], but…they always explained themselves and what to do…. They listened to me a lot." Giovanni, who worked in hospitals, found that the nurses knew more about what he needed than he did through their explanations. He shared this about a specific nurse he felt made a connection with him:

> One of them came in the room and sat down, talked to me. And not only asked me about what was going on with me but asked me about the room that I was in, was that comfortable, because there was a patient next door that was loud and yelling. So, she was making sure that I was not only, you know—[she] explained the medications and stuff to me but was I comfortable there. And she explained why being comfortable was part of the healing process, yeah.

As anyone knows who has worked in clinical care in 2018, the practice of repeating back something said (e.g., a physician's order) has been an effective safety measure. This tactic was mentioned by 22% of the participants. Diane, who had many special needs whenever she went to the hospital (which was often). This time, she was pleased with the night shift nurse who admitted her and to whom she explained her situation and in what ways she needed his help. Her recollection follows:

> There was a male nurse that was on duty that night, and he came in, and I explained to him a little bit of what was going on and that there was blood and that there was a urine infection, and I said, "There are certain things—I brought my apnea machine with me—[that] I need help with." So, he set that up for me, and I knew he was listening because he stopped everything, and he repeated what I said. I told him what special things I'm going to need before I was put to bed, and he just marked it all off, wrote it down, and then as he would do it he'd scratch it off the list and say "Okay, what's the next thing I should do?" So, he completely opened himself to listening to every word to make his job easier.

Giving help/assistance when needed or requested was a behavior that, intuitively, made patients believe they had been heard. The patient asked—the nurse fulfilled the request. I was surprised to see that only 22% of participants mentioned this behavior. Perhaps it seemed too obvious. However, Lottie, a 74-year-old single African-American clerical worker did need assistance and felt the way the nurses responded showed they were listening. Said Lottie: "They asked me what my need was, and if I was comfortable. But then they…changed my IVs. And one nurse did not know how. And she kept punching me and punching me and I told her, 'No more!'" After complaining it

hurt, Lottie asked for someone else and "that's when they called in the specialist" who was able to insert the intravenous line (IV), to Lottie's contentment.

Having the nurse notice the patient body language or cues helped put the patient at ease. Carol was rushed to the hospital for emergency surgery. While in the pre-operative area, Carol was anxious and fearful, awaiting the surgical start time. She said that the nurse "knew I was getting anxious because they weren't picking me up, and she, every two minutes, she would come and say, 'I'm checking. I'm checking. I'm making sure. They're not forgetting you.' So…every time she saw my face she knew if I was stressing and she would come back" and would give her reassurance.

Jean agreed. "He could see in my face the pain I was in. So, he recognized—pain recognitions with my face. And so, he just stepped up the pace from there." She continued: "He was a doer…. He'll look. He saw I wasn't feeling good. He wanted to make sure my pain pump was working properly and stuff like this. That was the first time I've seen somebody come in like every 20, 30 minutes."

Whereas many of the codes could be placed in more than one category or under more than one theme, that was perhaps most true for the experience of having the nurses believe what the patients are telling them about themselves. However, after hearing stories from patients who were not believed about anything from their pain status to their physical abilities or infirmities, this code was placed in the realm of safe patient care. The results of a study by Irurita (1999) supported this action:

> Contributing to care [being able to participate in their own care, being listened to—nurses acknowledging that patients 'know their own bodies']. This aspect of

> preserving integrity also increased the patient's level of control and, in some cases, reduced the risk of errors and omissions of care (p. 15).

Diane's statement illustrated why. She wanted nurses to know this: "Please listen to what I'm going to tell you, because you have to keep me safe." As Ref stated, "I've learned over the years you have to be very much your own advocate. You have to question everything, because nobody knows me as well as I know me." Nate, a 61-year-old married Caucasian firefighter had orthopedic surgery and was dealing with pain during his admission. He felt he got excellent care, not least because, as he put it, "…when they would ask how I was feeling, what was my pain scale, I felt they took what I said, and they believed it and they gave me the appropriate medication."

Because communication was key to assuring smooth transitions, when nurses made a point of telling the patient that they were passing on information to the next shift, the patients felt very reassured. Richard said: "They would write notes down and pass it on to the other people and other aides and made sure [because] I was having swallowing problems." Holly noted that:

> …when we would have shift changes, they were very good about coming in and letting me know that, "I'm your nurse and I'm now going off shift, I would like to introduce you to the person that will be taking over." They would do sort of the chart share, if you will, like, "This is what I'm handing off," very specifically. They did it in my presence so that I could participate in that and be sure to ask questions as a part of that process.

Kitty, who was so worried about vomiting, felt better when, speaking of her nurse, “She was writing things down when I talked to her and she said she would pass it along to the next shift.”

Unfortunately, in Kitty’s case, whether that information was passed on is not known. If it was, the next shift did not act in a manner that suggested they understood her concerns. That leads to the next main category: nonlistening behaviors.

## Research Question 2:

## Which Nurse Behaviors Implied Listening Had Not Occurred and What Were the Emergent Themes?

Although no code representing the nonlistening behaviors was as endorsed to the same extent as several of the nonverbal listening codes (e.g., eye contact or follow through), there were many nonlistening behaviors that had more than a few who described them, and when they did, they were accompanied by stories of anger and pain and fear. There was passion in the telling. So again, in descending order by number of times mentioned with percentages rounded for clarity, the following codes describe the way in which participants perceive nurses’ verbal and nonverbal behaviors as nonlistening (Table 9).

Whereas many of the listening behaviors had moderate to strong agreement, codes that make up the nonlistening behavior category were passionately felt but less universally agreed upon, i.e., not identified by greater than 50% of the participants. Although there were 13 codes mentioned by greater than 25% of participants, the highest percent in agreement about any one behavior was 43.5% for lack of follow-through. No code was identified by more than half the participants. Potential reasons for this have

been discussed in Chapter 5. Table 10 has placed the previously listed nonlistening behavior codes into themes that seemed to capture the essence of the behaviors as perceived by the patients. As with Table 7, behaviors with adjacent percentages were those mentioned by at least one quarter of the participants. Themes for nonlistening behaviors included the following. Examples for each theme have been presented.

- Arrogance
- Abuse of Power
- Incivility/Insensitivity
- Abrogating Professional Role Responsibilities

**Arrogance**

To be clear, arrogance was a theme that described the perception of the nurse when he or she behaved in any of the ways identified above and discussed below. Of course, the terms used to describe the themes have been subjectively determined and appointed. The term "arrogance" was chosen for this category because the actions described by the participants indicated that the nurse's objectivity was more to be trusted than the patient's subjectivity, even if that judgment related to subjective concerns (such as pain or physical ability) that only the patient could possibly know. It also encompassed acting in a manner that dismissed the patients' right to participate in their care and which reduced their humanity.

**Not believing the patient.** Because 30% of participants had stories that supported this code, Not Believing the Patient is discussed on its own under the theme of arrogance. The previous category of Listening Behaviors ended with the first half of Kitty's story. We last saw her when she was put at ease by the day shift nurse who wrote

Table 9

*Patient-identified Nonlistening Behaviors*

| | # Who Identified | % |
|---|---|---|
| Verbal | | |
| Discounting/making light of patient concerns | 9 | 39 |
| Arguing with the patient | 7 | 30 |
| Rejection of patient input | 5 | 22 |
| Sarcasm/Rude responses (e.g., "suck it up") | 4 | 17 |
| Making up excuses | 4 | 17 |
| Not assessing, not asking about the patient's status | 3 | 13 |
| Making promises that can't be/weren't kept | 3 | 13 |
| Speaking in language patient does not know (over them or near them) | 2 | 9 |
| Depending only on the chart; no patient input | 2 | 9 |
| Stating/conveying they are too busy to help | 2 | 9 |
| Not assessing patient readiness to learn | 2 | 9 |
| Not assessing patient understanding | 2 | 9 |
| Gruff tone of voice/Attitude | 1 | 4 |
| Cutting off attempts at conversation | 1 | 4 |
| Talking over/Not including the patient | 1 | 4 |
| Refusal to clarify an order patient says was written | 1 | 4 |
| Blaming others for things that were the nurse's responsibility | 1 | 4 |
| Nonverbal | | |
| Not following through | 10 | 44 |
| Not believing the patient | 7 | 30 |
| Dismissing patient concerns as unwarranted | 6 | 26 |
| Not trying to understand | 6 | 26 |
| Lack of eye contact | 6 | 26 |
| Lack of presence/awareness | 6 | 26 |
| Not trying to find solutions | 6 | 26 |
| Rolling eyes/Acting put out | 5 | 23 |
| Focusing elsewhere (e.g., on the computer) | 5 | 23 |
| Not keeping a promise (no explanation) | 5 | 23 |
| Lazy/ "I don't care" body language | 4 | 17 |
| Rushed/Scattered/Distracted | 4 | 17 |
| Insensitivity to patient readiness | 3 | 13 |
| Ignoring attempts at communication by the patient | 2 | 9 |
| Use listening behaviors and then ignore | 2 | 9 |
| Lack of physical contact/therapeutic touch | 2 | 9 |
| Standing at a distance | 1 | 4 |
| Acting like certain tasks were beneath them (e.g., making a phone call) | 1 | 4 |

Table 10

*Participant-identified Nonlistening Behaviors with Themes*

| Verbal | Nonverbal |
|---|---|
| **Arrogance** | |
| • Sarcasm/Rude responses<br>• Speaking in language patient does not know<br>• Blaming others for their unfulfilled responsibilities | • Not believing patient (30%)<br>• Dismissing patient concerns as unwarranted (26%) |
| **Abuse of Power** | |
| • Discounting/making light of patient concerns (39%)<br>• Arguing with the patient (30%)<br>• Rejection of patient input (22%)<br>• Depending only on chart; no patient input<br>• Refusal to clarify orders | • Not trying to understand (26%)<br>• "I don't care"/lazy body language<br>• Standing at a distance |
| **Incivility/Insensitivity** | |
| • Making up excuses<br>• Making promises not kept<br>• Gruff tone/Attitude<br>• Cutting off attempts at conversation | • Lack of eye contact (26%)<br>• Rolling eyes/Acting put out (22%)<br>• Focusing elsewhere (e.g., on the computer; 22%)<br>• Not keeping a promise and no explanation (22%)<br>• Ignoring attempts at communication |
| **Abrogation of Professional Role Responsibilities** | |
| • Not assessing, not asking patient about status<br>• Stating/conveying too busy to help<br>• Not assessing patient readiness to learn<br>• Not assessing patient understanding | • No follow-through (43.5%)<br>• Lack of presence/awareness (26%)<br>• Not trying to find solutions (26%)<br>• Rushing/Scattered/Distracted<br>• Insensitivity to patient readiness<br>• Using listening behaviors and then ignoring<br>• Lack of physical contact/therapeutic touch<br>• Acting like certain tasks are beneath them |

down Kitty's concerns to pass on to the next shift. Then shift change happened. According to Kitty:

> The next shift didn't care. The next shift was like I had been into a different world really. I was very surprised because the reason I went all the way to this hospital from where I live was because the nursing staff was supposed to be good. And the night shift person…same thing. I was nauseous again and because I had surgery on my neck I did not want to throw up. So again, I was like, "Okay, I'm super nauseous" and the guy comes—it was a man this time. He came in with a pill and I said, "No. No, I have an order for an injection," you know. And he said, "No you don't." And I said, "Ah, you need to go check because I do," and it was late. It was probably midnight. And so, then the charge nurse came in and—also with attitude from the very beginning—and said, "Well, we've got a pill here for you." I was so mad, but I felt very vulnerable because I was kind of out of it from being on morphine, and I felt a little bit like, these people could hurt me. Not that they would try, but just like, you know, what am I going to do? Hand me the phone; let me call the doctor!

Kitty said that the nurse just said, "No, this is what's ordered for you." Her response: "I know that's not true." Kitty had a longstanding relationship with the physician who understood her reaction to anesthesia and made sure Kitty knew he had written an order for an IV medication. She was not believed. The unfortunate outcome of this scenario has been discussed below.

A second example of this theme was relayed by Anita, the 90-year-old Hispanic widow. After hospitalization, she recovered for some weeks in a convalescent home.

Even though the site type (a convalescent home) is not the focus of this research, the action by the RN in the extended care facility demonstrated this category so well it has been included here. Anita recounted how her leg gave out and it took three people to get her up. Describing her attempts to stand, she said, "Sometimes I figure maybe they thought I was acting, but I wasn't." When asked why that was her perception she said, "…because they tell me—she thought I just wasn't helping with the weight on my leg…. I heard her say I'm not trying. But that wasn't the case, I just couldn't do it." When I met Anita at her own home, our interview occurred with her sitting on the edge of her bed because transferring was still too difficult.

This code is closely aligned with the only other one under this theme that received mention by over one quarter of the participants: dismissing patient concerns as unwarranted. The reason they are separated is because dismissing a concern does not mean it is not believed, just that it is not taken seriously. The behavior implied that the patient's concerns were invalid.

**Dismissing patient concerns as unwarranted.** A.M. was an 84-year-old divorced Caucasian retired RN. She had, within the past six months, endured both a shoulder and femur fracture repair. Even though she felt most of her care was fine (she said she didn't need much), she had only one complaint—that her concern was not taken seriously. She shared her story:

> My blood count was low, and my iron was low, so they decided to give me IV iron. So, the nurse came in and I don't have very good veins—she put a needle in and was administrating the iron, and I told her "It's hurting me a little bit," and she said, "Well, I'm checking, and I don't see it infiltrated, so I think we're okay."

> And we continued with it, and I said, "You know, it's still hurting me," and she said "Well, I'm checking, and everything looks good." So, she completed giving me the medication, and that was like a day before I was discharged, so I didn't actually notice anything on myself until I got to the nursing home, and then this is what happened.

At this point, A.M. displayed a large (possibly permanent) bruise covering the entirety of her inner forearm. This was nearly six months after the infusion was administered. As an RN, A.M. shared what she would have done had her patient voiced the same concerns. "I would've said, 'Okay, I'm going to take this out, and we'll do it in another area." She added, "I kept saying it was hurting me, but [the nurse] kept saying 'No, it looks good. It looks okay.'" She may have believed A.M., but she dismissed her subjective concern (pain). A.M. now has covered the resultant skin discoloration with makeup.

A second participant shared a similar encounter. Seventy-year-old Diane saw herself as a professional patient. She lived full time in a care facility and visited the local hospital frequently. She had many chronic illnesses and knew what did and did not work for her. During the admission she had had three weeks before our interview, she had this experience in which her concerns were dismissed:

> It was after a shift change, and the night nurse came in at seven. She quickly came into the room and said, "I'm your nurse," wrote her name down, and I told her, "I'm going to need a few things, a little help in getting ready for bed, because I've got an apnea machine with the mask on." So, she said, "Well, good. I'm not here to work right now. I'm just checking on each of my patients, and I will come

> back and help you." And I told her about the colostomy bag and when the last time it had been changed, and she said, "Well, I don't have to worry about that right now. I have to physically see my other patients." And I told her that there's a way that we do it that keeps me very clean, and especially since I was there because there was blood in the bag I wanted to make sure that we would get someone who would work with me and I could talk them through it step-by-step and make it very easy for them, but we can't just leave this here for five hours until you can come back because this is going to fill and overflow.

The short-term outcome was the nurse never came back. Some hours later Diane needed to use her call button to alert the staff that the bag was about to overflow. Feeling her concerns were dismissed, whether for the sake of expediency or out of hand, Diane shared this bit of wisdom with her nurse, originally conferred upon her by her colorectal surgeon: "There is no new doctor as smart as an old patient," feeling it summed up her feelings about this interaction. She needed to be taken seriously.

The other codes in this theme were endorsed by from one to four participants each. Only one was given its own section since the others, by nature of their titles, are self-explanatory.

**Sarcasm/rude responses.** Karen shared a painful experience. During her 19 days in the hospital, she had many encounters she said she will never forget. She shared, "I did have one nurse tell me to 'suck it up' because I was experiencing pain, you know, in my IV, and she looked at it and said that it was not clogged, although there was a very large backflow of bloodstream in the IV tubing." Whereas this exchange could also have

been placed with A. M.'s story of having her concerns dismissed, the rudeness of the nurse's comment was what compelled its placement in this different code.

Richard, who had some physical challenges that included poor vision, was puzzled and disturbed by the response he got when he asked the nurse her name. He said he thought the encounter was "an odd test of my patience." Even though there was a note on the white [communication] board in his room stating he did not have glasses, the response when asked for her name was, "My name's on the board." He responded, "Lady, are you testing me--?" and told his wife, "…this has got to be a test because my patience is really being pushed." It never occurred to him that someone in a caring profession would respond in such a way.

**Abuse of Power**

At first glance it may appear that the codes within this theme could be combined with those under Arrogance. However, arrogance is exhibited by more overtly rude behaviors, whereas abuse of power is the exertion of "inappropriate control over patients," including "being ignored or not listened to" (Irurita, 1999, p. 13). An inherent power differential exists between patient and caregiver; an intrinsic imbalance of power. Patients are vulnerable and, often, dependent on the nurse for information, connection, and for their safety, comfort, and well-being. When this power differential is exploited by the nurse, patients lose even more control than they have already forfeited just by being patients. Four of the seven codes within this theme had a greater than 25% participant endorsement. They have been discussed in descending order of number of endorsements.

**Discounting/making light of patient concerns.** By far the most widely endorsed code, discounting patient concerns, was perceived by 39% of participants as a lack of listening. Isabel's story continues and was exacerbated by her, albeit time-limited, dysphagia. She shared:

> During my stay I needed to dial out in order to let people know that I wasn't able to make it to a very important engagement and I was responsible for things [like ordering and picking up pizza for the group]. And I kept asking if they would dial out and contact these people for me so that I could let them know that I'm in the hospital. And that was pooh-poohed. I never—they never called out for me. They never called. They wouldn't call out…. This is the third nurse—she kind of was a little sarcastic and I got who she was, but she kept saying, you know, "Did the pizza get ordered for the Bible study, Isabel?" And you know, it was kind of like she was—I guess the best way to put it was she was just very sarcastic about it. And that call never got made.

Neon's experience with having her concerns discounted related to her pain management. Her story incorporated other aspects of this theme, such as arguing with the patient. As she related the encounter, she got angry just retelling it.

> It still gets my blood boiling. It was about three in the morning. I was in dire, dire pain. I needed something for breakaway pain between my pain pills and she did not read my chart. There was [an order] for breakaway pain and she did not acknowledge it. And I called her in because I was—I was crying hysterically. But she proceeded to say, "I don't know what you want me to do. I—I—it's not time for your pain pill." And I'm dying in pain. And she goes, "I don't know

> what you want me to do. What do you want me to do? Wake up the doctor?" I said no because …I didn't want to bother her. So, it [the pain] got worse and worse. And she just left the lights on in the room. And I couldn't get myself calmed down. I still had an hour and a half before my pain pill…. And so, she came back in and sarcastic with, "Well, why are you still crying?" And I went, "I am in so much pain." She goes, "Do you really want me to call your doctor?" and I said, "Yes, call my doctor." So, at about 4:30 in the morning she's calling my doctor and my doctor basically told her, "you look in her chart right now. She has stuff for breakaway pain and you give it to her immediately."

Neon related that, after receiving some medication to calm her and then her regular pain medication one and a half hours later, she felt better. But, she said, the nurse never checked on her again after 4:30 in the morning. The next person to check on her was the day shift nurse.

Tarek had to endure something similar. Not understanding yet what was wrong, he presented to the emergency department (ED) with pain and nausea. In the ED he was given a small bag to use for emesis, which he took with him to the medical/surgical unit upon admission. Once he got to the unit, the bag was thrown away because he had used it to spit in. He had not vomited yet. He continued:

> I had the nausea and I told her [the nurse] I was going to puke, and I wanted (the little emesis bag) back. She said, "No, we'll get you one of those (describing an emesis basin)." I said, "I don't want one of those, I want the little one so when I'm laying [sic] down, I could just have it next to my—…" "Oh, we don't have them, I have to go down and get them." I said, "Give me the last one." "Oh, we

threw it away." I said, "There was a million of them there, they're on every wall in the ED, can't you just grab me one?" "No, no, we only use these here."

The episode ended with him yelling at a nursing supervisor, a behavior uncharacteristic for this quiet, kind man. His position was, "What was the big deal? If somebody was in pain and they wanted to throw up and asked for a little freaking bag, let somebody go get it.... I don't want a bucket in front of me. I want to lay [sic] down, I feel like shit, I just want to lay (sic) in bed and have it next to [me]. I did throw up and I made a huge mess…."

**Arguing with the patient.** Many codes overlap each other, and many narratives fit in multiple codes or themes. In a sense, the above scenario with Tarek could also have been placed in the code arguing with the patient and this next story could have been placed under the code disbelieving the patient. Both would have worked. But to the patients the perception was that they were being argued with; emphasis was not placed on the "not being believed" aspect and this encounter was verbal, not a nonverbal disregard or act of dismissal. To illustrate this new code and to attempt to show the difference, Jean's late-night encounter with her nurse has been presented. She lamented:

> On Sunday night I could hear coming through the vent somebody hammering. And the—this is, like 11:30 at night and I'm like, what is going on? And then I heard somebody dropping boards. So, I called the nurses' station. They came down. "No, we don't hear anything. We don't hear it. And I said, "There is something going on. I can't sleep." And…it happened the night before. It turns out that they were doing construction in the basement…. They could finally hear

it and…it wasn't until 2:00 in the morning they moved me. I had no sleep. I'm trying to recover.

In the case of Diane, whose interaction with the too-busy-at-shift-change nurse was included above, the nurse also argued with her. After trying to get the nurse to help create a plan of care to address the colostomy bag, Diane concluded, "She seemed rushed, and she said, 'No, I told you I don't have to do that right now. I've got to check in with all of my patients first.'"

**Rejection of patient input and refusal to clarify an order.** Said Ref, "Nobody knows me as well as I know me." That sentiment has been the basis for patient frustration when their input about their own care has not been valued.

Closely aligned with arguing was rejecting what patients had to say about their own status or care. This code was well-described by Diane. In her many interactions with in-patient nurses, she found that "there were nurses who would listen to my tale of how to [deal with the colostomy stoma and bag] and keep me well, and then there were other nurses who just said, 'I've been doing this job a long time. I know what I'm doing.'" The patient's suggestions were rejected because the nurse felt she knew better. The same was described in the tales from Kitty and Neon, above. In Kitty's case, her nurse refused to clarify the order Kitty was so certain was written and was, indeed, in the medical record—a code with just the one advocate. This was included as its own code because of the egregious nature of this rejection of patient input and the physical, mental, and possibly legal ramifications of not following a written order.

Patients also picked up body language clues from the nurses, passive implications of superiority and abuse of power. The perceptions were that the nurse did not care about

the patient or the work, or that he or she was lazy. Lily described her "weird" encounter with one nurse: "She looked at my daughter. She looked at me. But I don't think she saw us. She was just not there. She seemed like she wasn't present…. She was very nonchalant…. It was a very strange thing…." As Ref pointed out, "When you want somebody…to know you're paying attention, you don't just sit back, you know, totally relaxed, looking at the ceiling." Kitty added to her story:

> [He] kind of sauntered in. "This is what you're getting. This is what's ordered." There was almost no indication that he was willing to call the doctor…. I knew I didn't need to call the doctor to get the order because I knew it was already there. So, I knew it was them and they were being lazy.

Finally, there were those who felt the nurses were not even trying to understand. The stories of Isabel and Kitty, above, highlight the frustration patients feel when they are trying to be clear and advocate for themselves but perceive there is willful disengagement (e.g., if only the nurse had checked the chart). Ref, too, had to fight to get to see his own records, the results of his blood work, before submitting to another blood draw. "I can't tell you that information because it's not our policy to give that information that we find to our patients" he quoted the nurse as saying. His response: "'Well, HIPAA regulations require you to provide it if a patient requests it.' And she didn't like that…and she left the room. It turns out she was violating hospital policy."

**Incivility/Insensitivity**

The most frequently endorsed codes in this category were the nonverbal behaviors, mostly having to do with the eyes: rolling the eyes, lack of eye contact, and focusing the eyes on things other than the patient. The fourth with at least five

endorsements is not keeping a promise and offering no explanation, which has as its corollary making promises that can't be kept, under the verbal portion of this theme.

**Lack of eye contact, rolling eyes, acting put out.** Believing that lack of eye contact implied the nurse was not listening made sense considering the heavy endorsement (65%) for eye contact implying listening. In the context of not listening, 26% of participants made the link to lack of eye contact. Fifty percent of that 26% linked the lack of eye contact with acting put out, sometimes shown by rolling the eyes. When asked what made her believe the nurse was not listening to her, Neon replied,

> She would not look at me. She looked away…. She was put out that she would have to look into my file and so she would look away from me and not—she'd go straight to the computer next to my bed and not even look at me, not even check me, not even check my blood pressure, nothing.

Ref felt that "most nurses…don't really make eye contact with patients." He continued, "They're either looking at the wall or they're looking at their bedding or they're looking at, you know, their chart or something. But it's when they're looking directly at you and they're acknowledging when you say…" and then he continued a story of determining pain level to show what listening is.

When sharing her experience of discharge teaching, Carol lamented that the nurse went through it so fast I didn't—I wasn't even listening. I just figured, you know what, we'll read it at home. She doesn't even care. She just wants to get through it…. I don't even think she looked at me. She was just going through the motions.

She went on to say that there had been no eye contact. Instead, Carol added, "I

think she [finally] looked at me when it was over and said, 'Oh, are you okay?' and I just said, 'Yeah,' because I wanted the hell out of there."

Kitty, continuing the scenario shared above, said, "In my mind now after the fact, I almost picture the guy rolling his eyes…. Like if he turned his head he probably rolled his eyes, but the feeling was very nonchalant…."

Karen's scenario also brought in other codes in this theme, namely tone of voice/attitude and cutting off attempts at conversation. When asked about any interaction she had where she felt the nurse was not listening, she shared this scenario:

> As a nurse, I knew when I can see an IV bag completely empty that it didn't get emptied in 30 seconds…so when I would have to consistently hit the call light to get someone to respond, it was a tone of voice, "What is it that you need? What do you want" over and over and over again…. So, to be treated that was and I felt that I was imposing on whatever else they were doing and the gruffness in the tone of voice and having numerous times after I called the first time to have to keep calling, saying, "Okay, is someone going to come in? Is someone going to come in?

When asked about her sense of whether she could have approached her nurses about concerns she had during hospitalization, she responded,

> I felt that I was not able to do that because I was cut short. No matter what I attempted to have a conversation about, it was very matter of fact and I felt that I did not fit into their schedule or whatever schedule they had, that it was more about their schedule than it was about me as the patient. I don't recall eye contact at all, I don't recall, with the exception of changing tubing, any type of physical

> connection; I don't recall it at all. Everything was almost to a script, very cold and scripted. I got to the point where I just didn't want to be bothered anymore because I was able to have my needs, my emotional needs, met with non-nursing [EVS staff].

**Making excuses.** After Tarek was done reliving his drama over the emesis bag (described above), he wanted to give this advice to nurses everywhere: Don't make excuses; just make it happen.

> It's so simple. None of this needed to happen. All they had to do was get me that bag. It's not like they had to drive or call and order it; there was an abundance of those bags on the floor, because I seen [*sic*] them on the walls…

Lottie, for her part, felt the nurses were giving her the runaround. Although that may not have been true, that was her perception. Although she liked her physician, at this moment she wanted to hear what the nurses could do to alleviate her pain.

> I was frustrated because by me being a patient, and if I tell you and make you knowledgeable of my concerns and what's bothering me and the pain, then I feel you should go through every, every extent to correct that. [Instead], they just gave me a bunch of comments from the doctor. Yeah.

Ref felt like he was being lied to when he was not allowed to see the results of his previous lab draw before getting the next lab draw. He compared those who listened to "the people that were not listening and, you know, coming up with bullshit excuses, in my opinion. Those are the people that I don't trust and…they're the ones who are trying to give me medication."

**Making promises that are not kept.** Ref was also one of three that equated making promises you cannot/will not keep to not listening. In what was to be a solution to his complaint about not getting to see his own chart, a nursing director promised she would post his results on line. He continued,

> But then, the director of nursing…did give me the information, but I didn't have anything to write it down on. So, I asked if they could email the information to me, and she said that they would post it on their website, but it took over a year to get them to start posting information.

Whether the promise was not kept, or the expectations were not properly communicated, this interchange came across as a broken promise—even though the results were ultimately posted. This was the patient's perception and it became his reality.

Another scenario, one with serious physical and mental consequences, was the lived experience of Bella, a 72-year-old Native American widowed retiree who was discharged just two weeks before our meeting after having had a pacemaker placement. A fragile lady with many serious allergies, she took great pains to communicate to her healthcare team the consequences of using plastic tape on her. No narrative from Bella has been shared thus far because Bella's only input was about this very traumatic hospitalization, about which she was in tears during part of the interview. The scene began with Bella in the pre-operative area.

> And so, they put this red [allergy alert] band on me and I said, "Now guys, be sure to listen. Be sure to read and look at my chart…. You should not…put plastic

tape on me." I'm very allergic to plastic tape. And they said, "Don't worry, we've got it covered." And I said, "Okay." I trusted them; trusted, trusted them.

The next part of the scenario has her in the operating room. She continued:

I'm looking up at this one nurse, male…and I said, "What did we talk about in there? No plastic tape, right, on this" because I had discussed this with the doctor. So, he said, "Okay, we'll make a note of that." And I said, it's plastered everywhere on my chart at the hospital. You've got a copy of my allergy list." And he said, "Got it covered."

Her narrative continued in the same vein with a back and forth between her and the various staff she encountered before anesthesia. Each time, she was guaranteed there would be no use of plastic tape. When she awoke from anesthesia, she found her surgical site covered with ice packs. She continues from there:

I couldn't see anything at first until the pack came off and I have plastic tape over me. I have about a three by three band over me here, here, here, and here. And I'm saying to the nurse, the nurse that was coming in to take care of me, I said, "They put plastic tape on me. They didn't put paper tape on me. They didn't put paper tape on…. They didn't listen to me!" So, I had one, two, three, four, five, six, seven, eight blisters under that tape that when they took it off, my skin, blisters, everything came off with the tape. And it was extremely burning, painful. I feel like there's bees stinging me right now and I can't stand it. Nurses did not listen to me.

**Abrogating Professional Role Responsibilities**

**Using listening behaviors and then ignore.** The case of Bella and the plastic tape, above, was the prime example of this code. She was assured by everyone with whom she spoke that she was heard and understood. As she noted, the staff nodded, documented her allergy to plastic tape, acknowledged her request, and assured her she had been heard. In other words, they used listening behaviors well. However, the outcome belied their assurances.

Carol received similar assurances without the resulting action. Having just returned from bowel surgery the previous day, she thought, as she sat in her bed, that she had a precipitous bout of diarrhea she couldn't control. Mortified, she shared her predicament with the nurses who came in at shift change for bedside report. She related the incident:

> I couldn't move. I was just paralyzed because I didn't want to move. So, they both came in at 7:00 and I said, "Please, can you just look? I don't know." She said, "We're changing shifts. I'll be back. I won't let you stay there." I called my husband an hour later, over an hour, crying. I said, "Nobody's coming in. She said she would be back in." So, finally she came in and I laid into her. I said, "It's humiliating enough for me to be here and you could not give me 10 seconds of your time and you've made me sit here for an hour." It was over an hour. And she said, "I had no idea it was that long." Did not apologize. Nothing. So, she finally looked, and she said, "You're clean. It was just the gas from what they gave you." It was like I was intruding on her time. Her face was deadpan.

**No follow-through.** Under the theme of abrogating professional role responsibilities, lack of follow-through was the code most endorsed by this study's participants. Almost half (44%) mentioned this, which made sense given its corollary, follow through/action/timely responses, cited by 60% of participants as a listening behavior. Examples abounded. In their words, participants shared this frustrating scenario.

As mentioned above, Isabel shared, "I kept asking them to dial out and contact these people for me so that I could let them know I was in the hospital. And that was pooh-poohed…. They never called out for me. They never called."

For Neon, as described above, the nurse finally gave her an anxiolytic and something for breakthrough pain after much pleading from the patient. However, as Neon stated, the nurse "left, never checked on me again after 4:30 in the morning. Left her shift, didn't figure or find out; I had nobody in the room with me till the next shift."

In the case of Karen and the empty IV bag, the fact that she had to keep calling to get it changed multiple times, as well as the fact that she was met with attitude each time, translated to not following through and not listening. As she said, "I felt I was imposing on whatever else they were doing…and having numerous times after I called the first time to have to keep calling saying, "Okay, is someone going to come in? Is someone going to come in?"

Arlene, a participant not yet mentioned, was a 66-year-old single Caucasian RN released from the hospital 14 days before our interview after having had a sigmoid colectomy. She was very clear about the nurse behaviors she felt did not constitute

listening. She focused specifically on one night shift RN. As she described it, he came in at 7 p.m. and said:

> "'I'm your nurse tonight.' He didn't write anything on the whiteboard. He asked me if I was in pain and he said, 'You're due in an hour, I'll give you the Tylenol.'" He returned at some point, but it was long past the one-hour promised time and "said nothing." Instead, he hung something [like a piggyback medication] and "never came back [during the rest of the shift]. I then saw him again at seven in the morning and he…took my temperature. He said I don't have a fever and he charted…. And then he left."

**Lack of presence and related codes.** During her five-day hospitalization, Lily had only one interaction in which she felt the nurse was not listening. This perception was caused by the lack of presence or interest displayed by the nurse. After the nurse could not manage to change a bandage around Lily's head, both Lily and her daughter concluded that she "was crazy…. She wasn't listening. She wasn't responding. She was just doing haphazardly." She continued, "…this woman just wasn't getting it…. She seemed like she couldn't care less. She was probably tired. And she just wasn't there…. She just wasn't present. Her body was there but her mind wasn't."

Carol experienced this perception of lacking presence as well. She described the nurse's behavior: "I don't even think she looked at me. She was just going through the motions." This, of course, linked with not making a personal connection with the patient; many of the codes overlap. The same scenario as shared above also provided the codes of not assessing the patient's readiness to learn: "She went through it so fast, I wasn't

even listening" and not assessing whether learning had occurred: "I just figured, you know what, we'll read it at home."

Holly's disconcerting discharge has been documented above. Specific quotes have been included here again to support the notion that when nurses did not assess the patient's readiness to learn or whether they had learned, the patients believed they had not listened. To wit, Holly related that the fact that she was going home with a drainage bag had her "grossed out" and "freaked out," but her discharge teaching did not assuage any of her fears:

> They give you this quick training on what you're supposed to do with it, which I just stressed over that the minute I got home and I kind of felt like I wasn't trained enough to really understand what I should be looking for or what's normal, which is not normal.

Isabel experienced the same sense that the RNs were insensitive to her readiness to learn. Having just been admitted late at night with a developing stroke, the nurse kept prompting her to identify common objects (e.g., a feather, glove, hammock) displayed on a chart. Whereas healthcare personnel may recognize this as an attempt at continuous assessment of the stroke's extent, Isabel perceived it as insensitive bullying. Her take: "She tried to prompt me again with that little chart…. But, you know, I was at nowhere near that point because again, it was, you know, only hours after I'd arrived, [and] I'd only been asleep for a short time."

**Rushing/scattered/distracted.** Although only 17.4% mentioned this perception, it has borne closer scrutiny to determine which nurse behaviors gave patients this impression. Island Girl had an issue with only one nurse she believed was not listening

to her. When asked what made her believe that, she shared the following recollection, even as she admitted that the other nurses "sort of made up for it; they made up for her."

> Just busy, yeah, busy and just walking around. [She was] more scattered. Yeah, just scattered and then when I called her, and I go, "Well, (the sequential compression device) isn't even connected to anything," and [she says], "Oh…" and then the blame went to someone else. So, I don't like that. You know us [healthcare workers], we know better than that; you take it. So that rubbed me the wrong way.

Diane also got a sense of a rushed nurse. Included in this narrative was the nurse conveying that she was too busy to help—another code under this theme. In fact, Diane used the nurse's own words to describe how she came to perceive her as not listening.

> She seemed rushed, and she said, 'No. I told you I don't have to do that right now. I've got to check in with all of my patients first.' I had to press the button a couple hours later and show the [nurse's aide], 'This has to be emptied. It's too full; has to be emptied.'"

Clearly, Diane's concerns were not heard.

Jean mentioned many times her perception that the nurses often focused on the computer rather than, or before, the patient. This focus, in part, led to her perception of rushing. She describes the way in which she saw many nurses' behavior.

> They come in and hurry, stuff, stuff, stuff, I got to do, dah, dah, dah. "Oh, how are you doing? Are you okay? Are you fine?" Yeah. Dah, dah, dah. And they just seemed like it was—I have to get this in there. Everything had to get into the computer so quickly and they—that's where the patient care has gone out the

window. Because it's like, wait a minute. Mark it down, time, everything like this, but talk to the patient.

**Neither assessing nor asking about status.** Listening was not always perceived as what happened via one's ears. A case in point was Arlene's perception that she was not being listened to because her physical condition was not assessed. She felt "it would have been a little more assuring if he did an assessment like he's supposed to do. You know, pull the sheets back, listen to bowel sounds, look at the wounds." She had four puncture wounds from her recent surgery. She was even willing to concede some aspects of a full assessment were not necessary. However, there was no assessment of the primary reason she was admitted to the hospital. She described the interaction and her perception that the nurse did not "listen" to her:

> It would have been nice if he would have looked to see if there was any drainage or, you know, usual…stuff. But they don't really need to listen to my lungs or heart, if you don't want to. You should, but the wound is the most important. He didn't ask me if I was voiding. He didn't ask me if I was passing any gas. Nor did he try to listen to see if there was any rumbling. For somebody who has a lower colon repair, I would think that would be kind of important.

**Not trying to find solutions.** The last code to be discussed within nonlistening behaviors was one that 26% of the participants endorsed. When someone perceived that the person charged with helping them was not doing his or her best to find solutions, the result was frustration and, in this case, a sense that listening was not occurring. Neon's story, above, of being in dire pain with no pain medication due for almost two hours illustrated patient frustration with this behavior. The nurse's response to Neon's pleas for

intervention was to state, “I don’t know what you want me to do. It’s not time for your pain pill.” Jean had a similar experience with pain medication. The response to breakthrough pain she received from her nurse was, “Oh, we’re on a schedule. You can’t have a pain pill. You can’t have a pain shot. You can’t have this.” No offer of alternatives was made, including those that are nonpharmacologic and are in the purview of the nurse’s scope of practice, such as distraction, positioning, ice, etc. Just a final “No.”

Likewise, Kitty needed a nonoral medication for nausea. Yet, even after telling the nurse that there was an order in the medical record for such a drug (and begging him to check for it), the relief was not forthcoming. Only an oral version was proffered and the answer, “Well, we’ve got this pill here for you.” No suggestions of alternatives or willingness to explore other options.

For Ref, the offending attitude was the incorrect argument that the nurse was not allowed to share the patient’s lab results with him. Instead of researching what could be done, she instead just said, “I can’t tell you that information because it’s not our policy to give that information that we find to the patients.” He was later to learn that even that was not correct. But, even if it were, no other solution was offered.

In Tarek’s case of the “puke bag” as he called it versus the emesis basin, the option given was not acceptable or therapeutic. No further solution was sought. He felt he had no choice but to resort to yelling at a nursing supervisor to get what he needed.

And, finally, Lottie, also struggling with pain, not only felt her concerns were not taken seriously, but also that the nurses should have been able to offer suggestions for

relief. As she put it when asked if she believed there was something more the nurses could have done:

> Well, I'm not a doctor, I'm not a physical therapist, I'm not a chiropractor, but my concern is if you go to your doctor and tell your doctor you have a problem, they have been trained, they got degrees, and they should be able to look at it and say, "Now, let's see how we can help you."

Although she mentioned other professions, she was talking about nurses too—a point that was clarified during the interview. She lumped all professions into one group with power to make things happen and to solve problems.

## Research Question 3:

## How Did the Perception of Listening and Nonlistening Affect the Patient, Both In and Beyond the Hospital, and What Were the Emergent Themes?

During the interview session all participants were asked how both types of behaviors (listening and nonlistening) made them feel or what impact the behaviors may have had on them. The outcomes, actual and perceived, were listed, ranked, and categorized within superordinate themes. The passion was in the telling and the differences between the two are striking. Finally, outcomes for both perceived listening and nonlistening behaviors are ranked below (Table 11) in descending order by number of times participants mentioned them. Here too, the percentages are rounded for clarity.

Accordingly, Table 12, below, lists those outcomes, divided by whether they are a result of listening behaviors or nonlistening behaviors. Each side has three themes. For listening behaviors, the outcome themes were: (a) a sense of security, (b) mental and emotional well-being, and (c) comfort/physical well-being. For nonlistening experiences,

the outcome themes were (a) vulnerability, (b) mental/physical harm, and (c) feelings of abandonment.

Table 11

*Patient-identified Outcomes*

| | # Who Identified | % |
|---|---|---|
| Listening Behaviors | | |
| Feeling of comfort | 13 | 57 |
| Feeling of safety | 9 | 39 |
| Sense of nurse competence | 7 | 30 |
| More relaxed/Less anxious/Calmer | 7 | 30 |
| Trust | 6 | 26 |
| Feel that nurses get it/have their back | 6 | 26 |
| Feeling of being cared for | 6 | 26 |
| Maintained/improved patient wellness | 4 | 17 |
| Happier experience | 3 | 13 |
| More willing to collaborate with the plan of care | 3 | 13 |
| Surprised by ability to be comfortable | 2 | 9 |
| Feeling consequential (e.g., "I mattered") | 1 | 4 |
| Able to make self comfortable at home after discharge | 1 | 4 |
| Nonlistening Behaviors | | |
| Physical harm/Exacerbation of condition (e.g., increased swelling, ↑BP) | 10 | 44 |
| Anger/Resentment | 9 | 39 |
| Loss of trust | 8 | 35 |
| Situation worsened (e.g., pain) | 8 | 35 |
| Frustration/Anxiety | 8 | 35 |
| Question care quality/Lose confidence in care | 7 | 30 |
| Being scared/upset/fearful/insecure | 7 | 30 |
| Ineffective treatment/Subpar care | 7 | 30 |
| Felt less safe/more vulnerable | 6 | 26 |
| Felt less cared for | 6 | 26 |
| Mental anguish/Humiliation | 5 | 22 |
| Acquiescence against better judgment | 5 | 22 |
| Felt need for/to be own advocate | 5 | 22 |
| Sense of negativity/hostility | 4 | 17 |
| Refusal of treatment | 3 | 13 |
| Poor reflection on nursing profession | 2 | 9 |
| Doubt | 2 | 9 |
| Made to feel like an imposition | 2 | 9 |
| Inability/unwillingness to share personal information | 2 | 9 |
| Feelings of being perceived the wrong way | 1 | 4 |

Those codes with over 20% endorsement have the percentages listed next to the code, rounded for clarity.

Examples first have been given for those outcomes from listening behaviors. Participants agreed that they felt more protected and better able to relax when they perceived that the nurses listened to them. Each of the four codes within the Sense of Security theme were endorsed by over a quarter the participants.

**Outcomes from Listening**

**Sense of security.** Feeling safe, a sense of nurse competence, feeling that the nurse gets it or has your back, and trust are the codes underneath this umbrella theme. The individual codes in this and other themes are often included together in a scenario. As noted, 39% of the participants felt safe after encounters with a nurse they believed listened. When Neon shared the following about her favorite nurse Joe, she also included several codes, codes subsumed under other themes, in her narrative.

> I felt okay, you know, Joe's here today. I could relax. Things are going to get done. I'm going to be taken care of. Patients feel that. They know it, no matter they're half under on medication or whatever, they know when they're safe and they know when they're not.

Kitty was asked how the listening nurse affected her hospitalization. After a frightening night shift encounter, her response about the day shift nurse was:

> Well, it made me feel like, okay, she's got this. She understands the issue here, which I was already surprised that it was happening anyway because I told the anesthesiologist 14 time that no matter, I did not want to throw up after surgery. And so, I thought, 'Dang, I can't believe this is happening [not getting the IV

Table 12

*Patient-identified Outcomes with Themes*

| Listening | Nonlistening |
|---|---|
| Sense of Security | Vulnerability |
| • Feeling safe (39%)<br>• Sense of nurse competence (30%)<br>• Feeling that nurses get it/have your back (26%)<br>• Trust (26%) | • Loss of trust (35%)<br>• Being scared/upset/fearful/insecure (30%)<br>• Question care quality/lose confidence in care (30%)<br>• Feeling less safe/vulnerable (26%)<br>• Poor reflection on nursing profession<br>• Doubt<br>• Loss of faith in hospital<br>• Feeling like an imposition |
| Mental/Emotional Well-Being | Mental/Physical Harm |
| • More relaxed/less anxious/calmer (30%)<br>• Maintained/improved patient wellness<br>• Improved, more + patient attitude<br>• Feeling consequential (I mattered)<br>• Happier experience<br>• More willing to collaborate w/POC | • Physical harm/exacerbation of condition (44%)<br>• Situation worsened (35%)<br>• Frustration/anxiety (35%)<br>• Worsened mood (22%)<br>• Mental anguish/humiliation (22%)<br>• Acquiescence against better judgment (22%)<br>• Inability/unwillingness to open up |
| Comfort/Physical Well-Being | Feelings of Abandonment |
| • Feelings of comfort (57%)<br>• Feeling of being cared for (26%)<br>• Surprised by ability to be comfortable<br>• Able to make self comfortable at home | • Anger/resentment (39%)<br>• Ineffective treatment/subpar care (30%)<br>• Feeling less cared for (26%)<br>• Feeling need for/to be own advocate (22%)<br>• Sense of negativity/hostility<br>• Refusal of treatment<br>• Feeling of being perceived the wrong way |

> antiemetic she knew was ordered].' So, when I told her, she got right on it…. So, I felt like, okay, this is good, and I was going to be fine and the night would be fast, and I'd be out there in the morning.

Giovanni was the only one to make a distinction between what he called "seasoned" nurses and "new" nurses. Although he felt all the nurses were competent and listened, he was impressed with the proactivity and situational control by these so-called seasoned (e.g., experienced) nurses. He shared, "I knew when things were going to happen, they were already there. So, her explaining things to me and listening to what I said, I felt that she knew what I needed, you know, more than I did." Although he was in clinical (non-nursing) healthcare management, he was surprised by these behaviors as a first-time patient. "I felt that she…was listening to me and knew what I needed, so she was controlling the people that were coming to visit me enough that she said, 'Okay, that's enough. You need to rest and get better.'" As for the difference between the seasoned and more novice nurses he said,

> With the seasoned nurses, I never anticipated. They were there before I even knew I needed, let's say, pain medicines or whatever. With the newer nurses, I knew there was a little bit more lag in time before they came. They waited till the medication was done…where the seasoned nurses…would come in [and] would already have the pain meds with them and…say, "Okay, let's give it to you now because in half an hour you're going to need it."

Like Giovanni, Mickey commented on the listening nurse's competence and her proactive style. She also was impressed with the nurse's ability to just know how to make her comfortable. Speaking of the nurse, she shared:

> She came in. She introduced herself…. I was given pain medication and she wrote what time and what they were giving me. And then…she brought in a bunch of ice packs and helped; she just seemed like she really knew way better where they should go than I did, you know? I was in so much pain. I couldn't move. I couldn't even pay attention, and I was tired. So, it was just the way they set me all up and got me comfortable so that I could maybe sleep.

Later in the interview, she mentioned again with surprise the nurses' ability to predict how to make her comfortable. "They also knew where to put the pillows and how to support that a little. They put everything within reach of my good arm." This awareness and proactivity gave the sense that they were listening, even if was not by means of their ears.

For Island Girl, a possible cancer diagnosis frightened her. But having a nurse she felt listening made her feel "secure, like I was going to be taken care of. It was a scary moment for me the whole time until we got the biopsy back…."

Tarek, who very much valued the nurse making a personal connection with him (a behavior he equated with listening), felt that these conversations made him view the nurse as "somebody I could trust, somebody I could—she got personal, so she cared. She wasn't like, 'Let me spend time with this guy, I have nothing else to do.'" The nurse Federico, whose proactivity and narration of care Tarek termed "efficient," made him feel safe, like he knew what he was doing.

Having nurses who listened to him—and none that didn't, Joseph said, "It made me feel trusting. I trusted them and their care. And when they told me something, I didn't think of [whether] it was true or not." He says that his ability to trust came from

(a) the relationship that had been built with the nurse; (b) the knowledge that no one was trying to "pull a fast one" on him and give him less pain medication than was ordered; and (c) being educated about his medications. "Their care was exactly what the surgeon had asked for."

Isabel, when speaking of her preferred (listening) nurse said, "[She] made me feel like okay, this person, you know, gets it. This person has, you know, got my back." Those feelings lead to a sense of security.

Holly's positive experience led her to feel "very much that I was in good, capable hands. I felt everyone was well trained in protocol and in etiquette." As an HR professional, she was the only participant to mention such niceties. She added, "I look beyond the obvious to see what kind of similarities there are in the way they do their job and I can see the good training that had gone in to the way they approach the patient." She felt comforted by the way they responded to a need. "There was just this sort of affirmation in them understanding [my need] and really dealing with it right away that showed me that they understood what I was asking." She continued, "I felt very strongly that they were very capable and that I could trust they were doing a good job."

Arlene felt the listening conveyed competence. "I was just kind of relieved that somebody was there that knew what a post-op patient is about!" Having been a bedside nurse in the past, she had an expectation that her caregiver would understand the patient population with for whom they cared.

**Mental and emotional wellbeing.** For Bella, before her trust was betrayed, she felt she had been heard. One can read, from her narrative discussed above, that she had reminded the pre-operative staff multiple times of her allergies to plastic tape and had

gotten multiple assurances that it would not be used. At that time, right before heading into the operating room, she said she "felt complete—when I went in that room, I felt completely relaxed, you know, trustworthy [sic] and just that they are nice people. You know, they were trying to bend over backwards for me and trying to make me comfortable…."

As has been shared, Island Girl was scared about pending biopsy results. However, the presence of nurses who listened made her feel secure, not least because they were…

> …making sure I was okay emotionally…. A couple of nurses knew where I was at and so they would come in and…ask me how I was feeling inside like, "I know you're scared, I know you're—but you're strong, you're going to get through this, we're praying for you." That always helped.

Karen had her share of nurses who did not listen. However, the one that did listen made her feel "very comfortable knowing that she was on the unit and any fears that…either were real fears about my illness or what was just going on in my head, I always felt, if she was there, I could handle anything." For Karen, the most important outcome of nurse listening was that it "made me feel like I mattered, that I was not a patient in a room, but I was *the* patient in my room."

Jean responded simply to the question of how the listening nurse affected her hospital stay. "Oh, it calmed me down" she said. Diane said, "I know for sure that I was more relaxed and less anxious, much calmer and much more willing to go through blood tests and everything that had to be done every day because I knew he had my back.

Diane, for whom sleep was an issue and whose discharge was delayed, valued having a nurse who listened. "Knowing most of them were listening to me, I was able to just sit back and say, 'Relax, go with this, sleep another night, go tomorrow.' It made it easier for me."

Having a nurse who listened to her gave Neon "a more positive attitude." She continued:

> Because he was positive I had more of a positive attitude by wanting to—I'm supposed to get up the next day. He would come in, 'Okay, time to get up. Let's, all right, you're going to do this today…. Everything was a positive step forward. And the positive step forward kept me from going to a rehab hospital. I was able to go home."

By his own admission, Ref was someone who "picks things apart," like people speaking unintelligently. But when the nurses listened, he said, "That made me more comfortable with knowing what was going to happen." He was more willing to follow his own plan of care knowing he had been allowed to partner in creating it. The same held true for Bruce, a 66-year-old married Caucasian teacher who was status post full arrest at home. Because the nurse challenged some of his thinking after listening to him, he believed it made him "a little more serious about [his] recuperation and to try to follow directions and not go rogue on them." He concluded that he should partner with them because, "obviously my safety was of importance to them and my healing was important to them. So, I didn't need to get in the way of that."

**Comfort/physical wellbeing.** Arlene's trust in her nurses' competence led her to say that it "gave me some comfort. I slept. I actually slept! I…don't worry as much."

Tarek also felt like he was able to finally get some sleep due to what he considered nurse listening behaviors. He said:

> I shared a concern where I can't sleep at night…. So, they were concerned. They wanted me to have a pleasant stay, they wanted me to get some rest. And when I asked them, "Can you not come in until six in the morning?" and they actually do it.

Once Jean was calmed down by the presence of the listening nurse, she added, "Bad as I felt, I felt like I was being taken care of. So, it gave me comfort." Isabel agreed. "The second nurse that I got, the one that I preferred, made me feel cared for."

One thing Carol's nurse did was never made her feel like she was intruding on her time. It also made her feel "really good." That was a gift for someone who was so scared and unsure of her situation. For Mickey, she was pleasantly surprised when "they were able to make [me] comfortable where I really didn't think that I could be comfortable." The fact that they "even anticipated [her] needs for comfort" made her very confident in their care.

As has been shown, listening to a patient yielded wonderful, powerful outcomes. The next section has addressed the equally-powerful outcomes that were generated when a patient did not feel listened to. However, most participants said that the experience from having been listened to was more powerful, depending on where it was during the stay and to what degree they were harmed by the nonlistening behavior, than the effects of the negative experience. Empathy and attentiveness are powerful tools in the nurse's arsenal.

**Outcomes from Not Listening**

Though few, if any, nurses begin their shift or their career with the intention of not listening to their patients, many have implied just that through their behaviors. Patients, then, have had an array of responses and feelings that can be, and often have been, detrimental to their wellbeing and recovery. This study's participant cohort experienced many of the same outcomes to a greater or lesser degree. Their perspectives have been shared now, categorized within the three superordinate themes of (a) vulnerability, (b) mental/physical harm, and (c) feelings of abandonment.

**Vulnerability.** Of the eight codes within this theme, half were experienced, or at least mentioned, by greater than 25% of patients. The most commonly experienced responses were: (a) loss of trust; (b) loss of confidence in/questioning quality of care; (c) feeling scared/upset/fearful/insecure; and (d) feeling less safe/vulnerable. The other four were mentioned by two participants each. They included (a) not listening as a poor reflection on the nursing profession, (b) doubt; (c) loss of faith in the hospital; and (d) feeling like an imposition on the nurse's time.

When two nurses were speaking over Isabel in their native, non-English language (considered a nonlistening behavior), her dysphasia made it impossible for her to question them about the content of their discussion. This affected her: "What scared me was…what are these, you know, these guys are talking about me and here I'm, you know, sick; like, what's my care going to be like?" She continued, "…it made me feel like, oh, my gosh, I must be pretty bad-off for these people to be rolling their eyes and talking in another language in front of me!"

Nate was one of only two who felt the negative experience of not being listened to

reflected poorly on nursing. His comment was, "It leaves a bad taste in their mouth about that profession." He agreed that each person represents their profession to the patient. The other participant who agreed had once been licensed and worked as an RN herself.

Kitty's traumatic experience with staff she felt neither listened nor cared affected her in many and diverse ways. "I was so mad, but I felt very vulnerable because I was kind of out of it from being on morphine, and I felt a bit like, these people could hurt me." The transition from listening to nonlistening nurse was jarring.

> I felt like, okay, this is good, and I was going to be fine and the night would be fast, and I'd be out there in the morning. But, yeah, then the night thing really threw me into a totally nontrusting situation where I felt like I needed to have a family member come…. And then, it makes me question if I would go back to that hospital even though it has a fantastic reputation and the doctor seemed shocked after this happened, and I believe him…. It made me feel like I was on my own.

Carol, too, lost faith in the hospital where she felt the nurses did not listen to her. "I had a pretty good feeling about it [the hospital]. But from that night of the shift change, totally changed. I'll never go back to [that hospital]."

Lily and her daughter experienced the nonlistening nurse in different ways. Her daughter was angry, and Lily was frightened. Said Lily:

> I thought, well geez, she's the nurse. Why can't you do this? And my daughter was just angry. But I was wondering mostly…I hope that the other nurses are not like this because she didn't know what to do. While you're at the mercy of the nurses there because you can't do what they need you to do or what they need to

do, it's kind of frightening because you really—it's up to them to take care of you. So, the nurses are crucial. And their ability to listen is crucial so that you are safe. If you can't trust and you think that they don't know what they're doing, and you can't help yourself because of the surgery you had, that's pretty frightening.

Although Island Girl's overall hospitalization experience was excellent, the one nurse who did not listen caused her to lose confidence. The fact that she had internal advocates within that facility helped. But she saw how upset her sons were and that caused stress. "I felt uncomfortable and then I knew the boys were really upset, just because they got scared thinking, 'Is she going to watch my mom?'"

Karen and Carol felt like impositions on their nurses, based on the nurses' feedback. Said Karen, "I felt that I was imposing on whatever else they were doing" since she had to continuously call for assistance and would get "gruffness in the tone of voice" when they responded to her pleas. As we have seen, Carol felt "like I was intruding on her time."

**Mental or physical harm.** This theme is composed of seven codes. All but one of them was endorsed by at least 22% of participants. The one most mentioned was physical harm/exacerbation. Almost half (43.5%) the cohort had a story that reflected this reality. The rest of the highest six were (a) a worsened situation; (b) frustration/anxiety; (c) worsened mood; (d) mental anguish/humiliation; and (e) acquiescence against better judgment. The final code, inability/unwillingness to share/open up was endorsed by two of the 23 participants.

Neon explained the effects of not listening on her psyche. Speaking of the nonlistening nurse she said, “She set me back about two days by doing that because I was—I couldn’t get past the pain threshold. So, it was probably mental what she did to me.” She then adds, “I felt like I was going to die in her care.” Jean added that when “she came to my room, my blood pressure went up twice, every time she entered…. My blood pressure went sky-high.” Carol used the same language: “I’m sure my blood pressure was sky-high, and I was so angry, and I was in so much pain.”

One of the more egregious outcomes described by a participant was the physical harm experienced by A.M., a retired RN. As described above, by dismissing A.M.’s concerns of pain at the IV site, the nurse’s actions caused A.M. to be left with a massive and possibly permanent bruising/discoloration along the length of her forearm; she now has covered the discoloration with makeup. “You know,” she said six months later, “it’s still hurting me.”

Isabel’s interaction with the sarcastic nurse who would not make the important phone call for her had a negative effect on her. When asked if she felt that behavior was one of nonlistening, she replied, “Yeah. Oh, completely not listening. It was—it was more frustrating for me. It made my situation worse.” The effect it had on Isabel carried to her post-discharge recovery. Isabel was someone who believed that it was less about “how the person is treating me. It’s, you know, how do I respond.” So, once she got home, Isabel continued to pray for that nurse and her personal life situation—the details of which she shared with Isabel.

Holly, with her drainage bag and limited understanding at discharge of normal versus abnormal signs and symptoms, experienced increased stress based on her lack of

comprehension about her own condition. She was "freaked out" and "grossed out," and she "just stressed over that the minute I got home and I kind of felt like I wasn't trained enough…."

Karen felt that her "anger and anxiety probably contributed to [her] staying 19 days" in the hospital.

> My whole person was not being attended to and I can't just break it down to the physical side versus—it's the whole person. So, that being said, the lack of connection…led to me being angry, changed hormonal levels, which probably then exacerbated my suffering; not pain but my suffering during hospitalization.

One interesting and somewhat surprising outcome was the acquiescence to questionable care by otherwise very strong-willed and confident adults, three of whom were currently, or had been, RNs. Kitty was one of those. After arguing with the night shift nurse and supervisor about her having an order for an IV antiemetic, they brought her a pill and insisted she take it, saying, "No, this is what's ordered for you." Kitty responded, "I know that's not true." But the nurse had the pill in his hand and insisted she take it. "And so," she said, "fine, just give me the pill," after which she eventually vomited. It was "early morning. It was great. It was right when the doctor walked in, I was throwing up. 'Do you see what's happening here? Like, I'm mad.'" The vomiting then affected her recovery. "My neck was more swollen. There was a little more bruising I think he said than normal." She also commented that she "couldn't sleep because I was nauseous then. So then, it was so annoying too, and then you're throwing up and what could be worse?"

Ref, someone very involved with and on top of his health regimen, had a similar experience with anticoagulants. He relayed the following scenario during his interview.

> When that nurse brought me some medication at 8:00 in the morning, I asked to see what the medication was, and I started questioning her, and unfortunately, I didn't realize I should've done that the night before when they brought me the higher dosage of the warfarin. And so, by not questioning it, I allowed myself to have the condition, which caused me to have the bleeding.

Karen and Arlene, both RNs, were similarly affected. Said Karen, "I did have one nurse tell me to suck it up because I was experiencing pain, you know, in my IV…." She continued,

> I sucked it up at the time because I felt it was just not appropriate, that I would write all this in my memory bank and then once I was discharged I would come back because I really wanted to not put anybody on the offense….

Arlene did not address the lack of assessment she had post-operatively from her night nurse. She said:

> I wasn't in a position where I felt I really needed to complain. But listen, here is—the daylight is coming, I'm getting a new nurse, my doc will be in soon, and I'll be getting a food tray. So why make a fuss? Why make a fuss?

And Carol, during her discharge teaching by the nurse who had not listened to her, just ignored the teaching because it seemed like the nurse was just "going through the motions." As documented above, Carol's response was, "I wanted the hell out of there." So, she and her husband read the literature at home themselves.

Humiliation and an assault to dignity were interwoven concepts. Ref, who was in for bleeding and a colonoscopy, had little warning before needing to use the restroom. Around 5:00 in the morning he said:

> When I buzzed for them… they were taking a long time to get there, and I know I leaked some blood. And then, when they finally got me out of bed to go to the restroom, I didn't quite make it all the way to the toilet before I bled and, you know, which made a big mess that they had to, then, have somebody come in and clean up.

Not only was this episode humiliating for a vibrant, cognizant man, it also affected his ability to sleep. "It woke me up quite a bit. I wasn't able to go to sleep again."

**Feelings of abandonment.** This theme also has seven codes that supported it, four of which were mentioned by greater than 22% of the cohort. These four were (a) anger/resentment; (b) ineffective treatment/subpar care; (c) feeling less cared for; and (d) feeling the need for/to be one's own advocate. The remaining three were (a) sense of negativity/hostility; (b) refusal of treatment; and (c) feeling of being perceived the wrong way by staff.

Diane's experience with not being listened to upset her. "It frustrated me," she said, "because if I was trying to give somebody instructions on doing something and they wouldn't listen, and they'd just say, 'I've been doing this a long time, I know what I'm doing,' then I would feel resentful." She continued:

> I was angry that my words didn't mean anything to them. I was anxious. I've got to watch every minute now to see what they're doing to me, because they didn't

believe what I told them, and it completely changes the day for you. You go from being relaxed and drowsy and catching up on your sleep to being upset and frantic.

Arlene felt she did not receive the normal standard of care. For one thing, the nurse did not ask if she was passing flatus. As she put it, "For somebody who has a lower colon repair, I would think that would be kind of important." She summarized:

> It would have been a little more assuring if he did an assessment like he's supposed to do. You know, pull the sheets back, listen to bowel sounds, look at the wounds…. It would have been nice if he would have looked to see if there was any drainage or…usual stuff…. Just kind of be ahead of the game.

Arlene claimed this did not affect her at all. Instead, she worried more about "the person who didn't know to look or who is not aware of" worrisome symptoms. Other participants also worried about their roommates or whoever would come after them.

Two participants refused to continue with their plan of care after feeling not heard by their nurses. Tarek complained about his IV site hurting. The nurse slowed down the drip but refused to restart it after Tarek's multiple complaints of pain and pressure. He continued:

> What made it worse, what made me feel that nobody was listening, is when they went to do the CT scan, they went to put the [contrast] in me but…it wasn't going through. I think it was going into the scan or something and it was very painful. I said, "Take it off right away." She [the CT nurse] said, "We need to do a new IV." I said, "I don't want to do it." So, I ended up not doing [the CT scan]. This was something they wanted to do before they let me go.

Several participants felt the need for an advocate, or felt they needed to be their own advocate. Kitty bemoaned the fact that she traveled over the hill to get better nursing care. "And part of it I did. I got great care and then it was—you know, it only takes one person to ruin an experience. So, would I go back? Yeah. I just would have somebody there with me." Similarly, Lily said, "If I had been by myself, I would've been more frightened." Ref, already mistrustful of the advice he had gotten from the nurses, felt the same way: "I basically, then, during the day, read up on what I needed to do to recover myself, and so, I basically took over control again of my own treatment process…." And finally, Jean shared this scenario in which she could have used an advocate:

> I'm stuck in bed and…I have to have somebody go with me to the bathroom…. I have to have somebody help me with the walker. I've got no control, so when somebody talks down to you, it makes you feel like dirt. That's how I felt. I felt like dirt because it's like I can't take care of myself. And they didn't—you know, but whatever's around their schedule.

## Research Question 4:

### What Advice do the Participants Have for Nurses as it Relates to Listening?

The last question asked of each participant was what, if anything, they would like nurses to know about listening. They shared many heartfelt suggestions based on their recent acute care experience. Categories included (a) connection, (b) the environment, (c) listening, (d) time, (e) trust, (f) from the patient perspective, (g) what nurses should do, (h) what nurses should not do. Each was conveyed below in the patient's voice.

**Connection**

- Engage the patient more so the patient will open up and tell you things that could help you care for them
- Get to know your patient on a personal basis. It creates a personal bond of trust and patients will believe you more and answer your questions better
- Do a proper introduction
- Understand that part (maybe the most important part) of the healing process is connection, the presence that a care provider should have with a patient
- Look at me before you look at the computer
- Try to get to know the patient as an individual
- Ask patients how they are (it could affect how they respond)

**The Environment**

- After moving patients around, leave them and their things as you originally found them
- Take in the entire environment when you listen
- When the patient uses the call light, there's a reason; please take it seriously
- Be aware of sleeping patients at night and curtail the laughing and talking where we can hear you

**Listening**

- Listening brings out compassion
- Listen carefully to what I'm telling you

- Listening is crucial because people are ill and need help or they could die
- When you're distracted, you're only partially listening
- The most crucial part of your job is listening to patients. To excel, you must first listen, then process what you hear, and then act
- Nurses are no good to anybody if they don't understand what the patient is saying or what the problem is. You must be listening
- When you listen, I believe you will advocate for me

**Time**

- Spend a little more time with the patient
- Take a few minutes to get to know the patient a little bit
- Take a few minutes to get some rapport going and your shift would be a lot nicer

**Trust**

- Control pain and give what is ordered (on time); don't skimp. It builds trust
- It is the nurse's job to protect patients and bring them through with as much comfort as possible and create a trusting relationship. If you can't do that you shouldn't be in nursing; you need to be in a field where you're not risking someone's life
- Listening builds trust

**Valuing the Patient's Perspective**

- Just because my body has failed doesn't mean my mind has
- Patients do not fit into a one-size-fits-all basket

- I am not going to say something unless there's something I really need
- We are individuals—we don't express ourselves exactly like you might.
- What we need to know is that we're going to be ok and what to expect, even if it's unpleasant
- Patients don't make up the issues they have with allergies
- Listening puts patients at ease
- We sense whether we're getting cared for or not
- Patients are fearful of the unknown
- The most important thing for patient "satisfaction" is whether the patients feels like human beings and that they matter
- Understand that every patient is different; if you give us compassion, we will get well quickly

**What Nurses Should Do**

- Be respectful
- Sit down, even briefly
- Look at the patient
- Use kind words; they go a long way
- Just touch someone and make sure he or she is ok
- If you think the request is unreasonable, ask more questions before saying "no"
- If the patient tells you something you don't know, check it out!
- You can save yourself a lot of time/effort if you just do it right the first time

- Repeat back what the patient said so we know you know what was said
- Do as much as possible to prepare patients for what to expect since we're not experts and have thousands of questions
- Tell patients what their experience will look like; set expectations, narrate care, explain why you're doing things and give a full picture, not partial
- Be honest
- Positively impact the patient's mental health
- Treat each patient as if it is his or her first time there or find out what he or she knows
- Look up from your screen or leave the computer outside
- You must invite the patient to talk to you
- Lay out the plan so the patient understands it
- Set realistic expectations *with* the patient
- When the request is simple, just do whatever it takes, and you'll avoid grief later
- Present yourself as someone there to help
- Ask what the best thing is you can do for the patient; you'll see a difference
- Partner with me in my care
- Be a guide

**What Nurses Should Not Do**

- Don't give excuses about why you can't do something without looking for another way to meet the need

- Don’t make excuses; just make it happen
- Don’t make up stories when you don’t want to do something. We can read you
- Don’t disbelieve your patient; that is akin to calling them a liar
- Don’t bring your personal life in when people are sick
- Don’t talk down to me
- Don’t say you have to do something, like the computer is telling you to do it
- Don’t use me as a guinea pig
- Don’t make patient feel like they’re interrupting your break or conversation when they call

## Summary

Chapter 4 summarized the results of this study by linking participant quotes to the various codes and themes inducted from the 23 interviews and answering four of the five study questions. The fifth question has to do with the effects that demographics may have had on the results, which have been discussed in chapter 5. Behaviors were divided into verbal and nonverbal listening and nonlistening behaviors. Outcomes were divided by those resulting from at least one encounter with a listening nurse (positive) and those resulting from at least one encounter by a nonlistening nurse (negative). A discussion of the findings, strengths, limitations, research implications, and significance for the profession of nursing have been presented in chapter 5.

# CHAPTER 5

# DISCUSSION

The way in which patients view and interpret nurse behaviors as they relate to listening has not been researched before now; at least I have found no evidence to that effect. This study sought to elicit and understand patient perceptions of nurse listening behaviors. Specifically, the goal was to discover, describe, categorize, and interpret these perceptions and any ways in which the behaviors impacted the patient both during hospitalization and after discharge, if at all. IPA was used effectively to meet this goal. When discussing the background for this study in Chapter 1, I suggested several rationales for pursuing it. These included clinical, ethical, financial, educational, and spiritual. All were vindicated by the study's results and have been discussed.

## Use of IPA as the Qualitative Method

Although cases of listening from contexts other than acute care and participants other than inpatients were discoverable in the literature, perceptions of nurse-specific behaviors by patients or others, especially in an acute care setting, have not been found. Hence, recent patients' accounts of their lived experience were elicited using semi-structured interview questions. Recently hospitalized medical and surgical patients were asked during face to face interviews to describe ways, both verbal and nonverbal, in which a registered nurse had behaved that caused them to believe the nurse was either listening or not listening. Trying to save me some driving time, one or two participants

asked if these interviews could be done over the phone. I never considered this an option because of how facial expression, body language, and other nonverbal cues are so important in communication. I believe that no other method would have yielded the trust, the candor, and passion, or the rich detail the interviews engendered. Eye contact and vocal affirmations would not have been in play either over the phone or, perhaps, in a focus group setting. The ability to see someone about to cry or struggle for the right word would have been lost using another method. Epistemologically, use of a nonpersonal survey, had one existed, would have only validated previous knowledge, not garnered the new understanding sought by using these study questions. Also invaluable was the opportunity to prompt participants who were obviously struggling to articulate their experience.

Because listening is so intuitive to human beings, some participants had a difficult time describing the associated behaviors. In other words, it seemed that they knew listening when they saw it but were sometimes hard pressed to know why they knew. As Siegmund (2017) avowed, "Listening is…a fundamental constitutive feature of the human person. By listening (is meant) a silent 'letting be' that reveals the ontological depth of the person" (p. 586). Therefore, prompts were used to stimulate participants to recall even subtle ways in which they experienced listening. Responses to the prompts yielded both verbal and nonverbal behaviors, some of which were experienced and endorsed by a large percentage of participants. An analysis of the results begins with the link to theory.

## Link to Theory

This qualitative study was conducted using a Heideggerian interpretative phenomenological analysis methodology and was guided by King's theory of goal attainment (TGA), specifically from the perspective or perception of the patient. The theory was used both to frame the study and to interpret its results. As suggested by Polit and Beck (2004), use of theoretical frameworks in research has helped to add meaning to the findings and make them more transferable. One assumption King made that undergirds the TGA was that the perceptions of the patient affect the communication process (Sieloff-Evans, 1991). That assumption was validated in this study.

As noted in Chapter 3, interpretative research has been used to place the experience of the phenomenon in the context in which it was found and to discover its perceived meaning, as opposed to simply elevating awareness about that phenomenon. That goal, too, was realized in this study. Not only were nurse behaviors (both verbal and nonverbal, listening and nonlistening) illuminated by the 23 participants, ways in which those behaviors affected them (i.e., the meaning they placed on the behaviors) were also identified (see Chapter 4). Once identified, it is up to nurses to understand perception "if they are to assess, interpret, and plan for a client's identification and achievement of goals that maintain health" (King, 1981, p. 24).

As has been noted, perceptions are the unique realities of each person experiencing the phenomenon—judgments made by inferring the meaning or intent of others' behaviors. Perceptions were aspects of what King termed the personal system in her grand theory of dynamic interacting systems, King's conceptual systems model (KCSM). Along with certain aspects of the interpersonal system (e.g., interaction,

communication, transaction, role and stress), the concepts found within both King's grand theory and her middle-range theory helped frame and support the data that reflected a positive (listening) encounter.

King (1981) wrote that human beings reacted based on their "perceptions, expectations, and needs" (p. 20). This study's participants have indicated that they expected to be believed and they needed to be heard. When those expectations and needs were not met, the pathway to goal achievement was altered. As King theorized in her TGA, the patient's perceptions of the nurse's actions led to independent judgments and action/reaction by the patient and then an interaction and ultimately a transaction with the nurse resulting in goal attainment (King, 1981; King, 1999). In this theory, the result was always goal attainment. However, what the results of this study highlighted was that the goal was often not set, not sought, and not attained; the nurse and the patient were not aligned. The designated pathway to goal attainment was compromised at the level of perception, due to the influence the patient's perceptions had on the interaction process, one of the assumptions on which the TGA was based (Sieloff-Evans, 1991).

King defined perception as "a process of organizing, interpreting, and transforming information from sense data and memory… [that gives] meaning to one's experience, represents one's image of reality, and influences one's behavior" (King, 1981, p. 24). When patient perceptions of nurse behaviors were unfavorable, the theorized pathway was not realized, leading to detrimental outcomes, the severity of which depended on the nature of the interaction. Because perception can be distorted by emotional states such as anger or fear (King, 1981), one can easily see how this could affect the acute care experience for patients. Many of the study's participants recalled

being angry or fearful when faced with a nonlistening nurse. Examples of this phenomenon were found in the experiences of Neon, Kitty, Bella, Isabel, Diane, Bruce, Karen, Tarek, Jean, and Carol. The anger or fear that resulted from the participants' interactions with the nurse (or nurses) affected their experience, and sometimes their health, their length of stay in the hospital, their trust level, and their safety.

Bruce admitted that patients are fearful of the unknown and that nurses need to address that fear. He stated that patients:

> are in a situation where a lot of what goes on they are not experienced and not knowing what's happening and fearful about what the outcomes will be, and I guess people would know that nurses see it all and part of their role…is the mental health of patients because good feelings are going to make better health or better outcomes and part of that has got to be hearing the needs of the patient.

For nurses to engender those good feelings and address the patient's mental health, they need to understand how to connect, create a trusting relationship, and allay patient fears of the unknown, with confidence and competence. To do this, they need to know how their behaviors are viewed and adjust them accordingly.

In King's TGA, reciprocity (i.e., mutuality or interchange) was foundational to the nurse-patient interaction in service of reaching a mutually-agreed upon goal. Merleau-Ponty (1945/1962) believed that true connection between human beings must include an element of reciprocity. Specifically, he explained that "in the experience of dialogue, there is constituted between the other person and myself a common ground; my thought and his are interwoven into a single fabric" (p. 354). Buber (1924/1970) tied it together with his observation, "relation is reciprocity" (p. 58). This means there will be

some give and take; some tradeoffs are made. One participant, Bruce, shared his story of having the nurse override his desire to "be lazy" with a plan she knew would be better for him. Instead of him viewing her behavior as bullying or unkind, he saw it as listening and they collaborated to reach the goal. Additionally, the TGA has what have been called interior boundary determining criteria. One of these is that the nurse and the patient are in a reciprocal relationship and that the patient "has information about self and perceptions of problems or concerns that when communicated to [the] nurse will help in mutual goal setting (King, 1981, p. 150). Narratives from participants illuminated the truth that only when the nurse believed and incorporated that communicated knowledge into the plan of care can the goal be set and, ultimately, achieved. Unfortunately, that was not always what happened. Figure 6 shows an alternate reality.

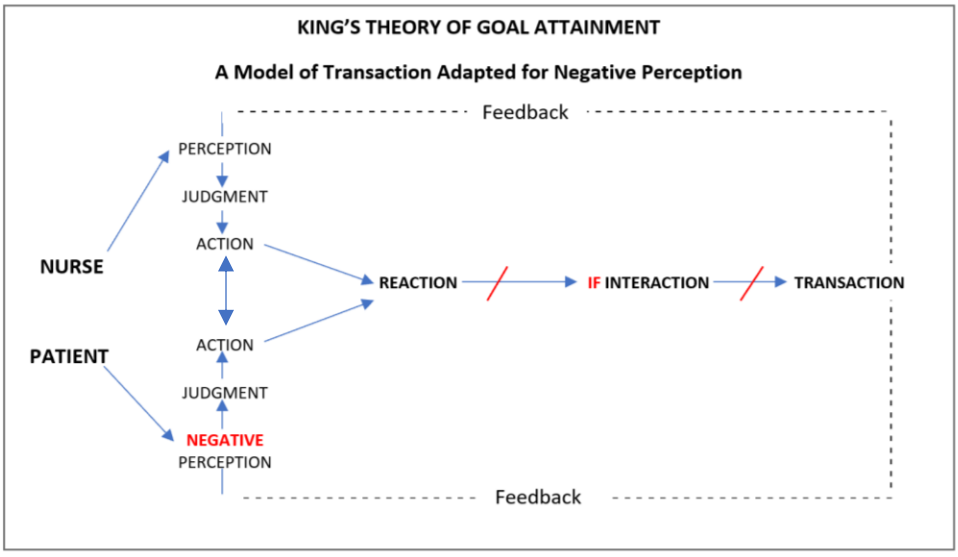



*Figure 6.* Adapted KTGA to reflect negative perceptions.

Three of the propositions that undergird the TGA are that (a) "if perceptual

accuracy is present in nurse-client interactions, transactions will occur; (b) if nurse and client make transactions, goals will be attained; and (c) if goals are attained, satisfactions will occur" (King, 1981, p. 149). To a degree, this was true. However, these propositions did not include what this research has shown to be an important qualifier. In this study, it became clear that if perceptions were *positive* (e.g., the nurse listened), not just accurate, transactions leading to goal attainment occurred. From that point forward, the goals, if they were set, were attained, and then satisfaction occurred. Perceptions can be accurate and negative. In those cases, Propositions 2 and 3 did not hold. When the perception was negative, as has been shown, trust was not established, goals were not set, and there was no satisfaction, at least for the patient. An alternative model to the TGA schematic representation shown in Chapter 2 is presented here to reflect findings when the perceptions were negative (Figure 6).

According to King (1981), transaction involved "bargaining, negotiating, and social exchange" (p. 147). When patients had a negative perception of the nurse's action, the process often stops at the point of reaction and a transaction never occurs. If an interaction does occur after the initial reaction, it will most likely be nontherapeutic and, again, there will be no transaction, no negotiation, and no social exchange. Instead, as the study results indicated, patients acquiesced against their better judgment, became incensed to the point of yelling, or, perhaps, gave up and shut down. To attain the goal, the nurse must listen, being aware of and adopting identified behaviors that imply that he or she is doing so.

### Question 5: Demographic Considerations

As noted in Chapter 1, perception differed for everyone because of its relation to person-specific factors such as experience, education, self-concept, socioeconomic status, needs, goals, temporal-spatial relationships, physiology, and values (King, 1981). Many of these factors were not included in the demographic questionnaire because they were beyond the scope of this study, but work experience and education were. Demographic questions and results were discussed in Chapter 4. The study's cohort included diversity in almost all demographic variables. Both sexes were represented. Participants ranged in age from 50 to 90 (where any age over 90 was coded as 90). There was diversity in ethnicities, marital status, years of education (although skewed towards more), length of stay during hospitalization, number of days since discharge, reason for hospitalization (e.g., medical, nonorthopedic surgical, neurological, or orthopedic surgical) and facilities, most of which were part of a system and differed in both geography and in type. Unfortunately, no public facilities were represented beyond the pilot study.

Cultural alignment was the only variable that did not have diversity. Although some participants considered themselves part of a hybrid culture, all participants related to American culture fully or mostly. I surmise that the requirement that the participant speak fluent English could have influenced this result.

The only variables that seemed to have influenced the narrative or experience were sex, facility (even though facility was not one of the formal demographic questions), and, arguably, age. Discussed briefly above, men seemed to have a more difficult time identifying what it was about the nurse's behavior that led them to believe he or she was listening. There were also three women (Lottie, A.M., and Anita—all

older: 74, 84, and 90, respectively) who had more difficulty with the concept. Those who struggled had to be given multiple opportunities to convey their perceptions and often given examples. Alternatively, if they perceived that the nurse did not listen, they were able to explain why without prompts.

Additionally, none of the men mentioned touch as a modality that they equated with listening, but eye contact was often a perceived requisite for both men and women; six of the seven men mentioned it. Only men mentioned silence as a listening behavior, and presence was a behavior only mentioned by women. Presence is a term that embodies some of the other individual behaviors endorsed by other participants, including men; it was a composite behavior. As defined, therapeutic nursing presence "demonstrates caring, empathy, and connection, qualities required to build rapport and trust between nurse and patient" (Boeck, 2014, p. 1). Perhaps the nuance of this concept was more accessible to female participants.

There were six healthcare systems represented: Dignity Health, Providence, HCA, Kaiser Permanente, Adventist Health, and Memorial Care. One free-standing facility was in the mix. Most of the worst reports were experienced at facilities representing just one of the systems, an organization with a good reputation in the community. Whereas almost every facility or system was linked in some way to a nonlistening event, most were not as egregious as were those from the one system. However, of the hospitals that made up that system there was little consistency. One had magnet status and the others did not. All had "very high" nurse staffing ratios. One was not represented by a bargaining unit; the others were. The Hospital Compare Overall Ratings ranged from 1/5 to 4/5. None were teaching hospitals. The poor nurse-patient interactions may reflect a

pervasive culture, or they may have been "one-off" experiences reflective of those individual nurses.

## Expectations and Findings

The analysis of the study's findings reflected a content analysis approach (who said or did what, to whom, and with what effect). As is true in content analysis, (a) the aim was to analyze a nursing sensitive phenomenon and explore the unknown; (b) both induction and deduction were used in analysis; and (c) a nonlinear analysis process was used in analysis (Vaismoradi, Turunen, & Bondas, 2013). The data told a story in answer to the research questions.

### Codes and Themes Supported by Literature

In Chapter two, literature applicable to the concept of nurse listening behaviors and patient perceptions was presented. Some of what was described in the literature was reflected in this study's results. Other realities or perceptions, however, were discovered de novo. Hence, here in Chapter five, I present literature in support of the codes and themes inferred from the study's results.

**Connecting with patients**. Connecting with patients was a clear mandate for conveying a sense of listening; that is, connection on a personal level. Over a third of participants addressed it. Making this connection did not require an inordinate amount of time or skill. It just meant taking an interest in who the patient was and what he or she had to say, not just what the patient had. As Thomas and Pollio (2002) noted, even a routine nursing task "can be transformed into a moment of powerful, personal connection" (p. 254). This connection can be achieved through asking and answering questions, personal conversations, providing a welcoming environment, and presence.

**Caring.** Nursing has been considered a profession that prioritizes nurturing (Wilkin, 2003). Nurses have been known for the care they provided. The participants in this study believed that nursing care should be combined with caring. Caring can be implied through connecting, which, as participant Carol stated, began with listening. Thomas and Pollio (2002) have agreed: "Patients want to be known, and cared for, in their wholeness, especially when their world is unstable…" (p. 255). Nurse theorist Kristen Swanson (1991) proposed five caring processes, two of which are doing for and being with (p. 163). This study has shown that, often, being with the patient was as important as was doing for the patient, maybe even more so. That was the presence that participant Karen described, which was conveyed through body language, sitting, not rushing, attentiveness, and other like behaviors.

In speaking of human relationship, Martin Buber (1924/1970) differentiated between the I-It and the I-Thou (or I-You) relationship. The former described an interaction with something that can be sensed, used, or categorized; something objectified. The latter was what was sought in a relational encounter by true conversation. His description: "Whoever says You…stands in relation" (p. 54). When we stand in relation, he continued: "He is no longer He or She, limited by other Hes or Shes, a dot in the world grid of space and time, nor a condition that can be experienced and described, a loose bundle of named qualities" (p. 58). That depersonalization, that perception of the other as a loose bundle of qualities, breaks the bond of human relation. Although patients often depended on nurses for physical care, it was only when the patient became an object for the nurse that this dependence "constitutes an indignity" (Irurita, 1999, p. 12). As Thomas and Pollio (2002) noted, "patients feel great resentment

when they are being treated by care providers as mere limbs and parts on a conveyer belt, moving through a factory-like assembly line" (p. 60). Entering an I-Thou relationship conveyed listening, giving patients a sense that they mattered; a spot of humanity in an oft inhumane environment.

**Collaboration and individualizing care.** Collaborating with the patient and considering personal preferences, behaviors endorsed as listening by this study's participants, also have been supported in the literature. In its 2001 treatise on quality in healthcare, the Institute of Medicine (IOM) found that "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" leads to improved care quality and patient experience (p. 6). Thirteen of this study's 23 participants (57%) agreed and spoke specifically about personalizing care. Another 26% described nonverbal nurse behaviors that they felt showed an understanding of and catering to individual preference, although 26% assigned "not trying to understand" as a nonlistening behavior. An additional 18% equated listening with the nurse's attempts to understand their perspective. Clearly, patients want and need personalized care; they need to be treated as individuals who matter.

**Prompting the patient to share.** Twenty-six percent of participants considered the nurse's efforts and prompts to get them to share, including on an emotional level, as a listening behavior. In an article focusing on medical students, Wilkerson, Fung, May and Elliott (2010) wrote, "Essential skills necessary for implementing a patient-centered clinical approach include the ability to elicit the patient's personal story, to explore health beliefs and preferences, and to negotiate a management plan that is respectful of those

preferences" (para. 1).

Based on the results of my research, this statement also applied to nurses. Attaining this level of empathy and inclusion required attentiveness and making a personal connection, made manifest through a variety of behaviors such as eye contact, speaking to the patient directly, not interrupting, talking to the patient before doing the task, use of silence, stopping other activities to listen, leaning in and other similar body language, and undistracted focus on the speaker, or presence. It also required including the family when desired. The Institute for Healthcare Improvement (IHI) has noted that "caregivers must also be willing to seek and respect input from patients and family members on issues both broad and specific" (2018, para. 17). This may be antithetical to many nurses' practice, but it was expected and desired by patients.

**Believing the patient.** Most literature in support of believing the patient focused on physicians, reports of pain, and women, in general, not being believed. All suggested this was poor practice. This study has shown that patients, both men and women, wanted to be believed in many different areas, not just related to pain, and not just by the physician. Thirteen participants gave examples of either not being believed outright or having their concerns dismissed or discounted by the nurses. These actions resulted in mental anguish, anger, anxiety, loss of trust, fear, and actual physical harm or exacerbation of the condition being treated. They wanted their self-care techniques incorporated into the nurses' plans. They wanted to be believed when they conveyed the understanding they had with their physicians about the plan of care. They wanted the nurse to believe them when they shared what has worked, what was harmful, or what should be avoided. Ultimately, believing the patient can be linked to ensuring safe care,

one part of the nurse's role codified in this state's statute (California Board of Registered Nursing, 2013).

**Unexpected Findings**

Beyond the unexpected negative reports from facilities in the well-respected health system, other surprising results were realized throughout this study. A Heideggerian approach was taken to this phenomenological study because of my perception that bracketing one's views, especially on listening behaviors, was not entirely possible, because all human beings have had experience with listening and their own perceptions on how to tell when it was happening. However, steps were taken, as described in Chapter 3, to enter the study with a mind ready to explore new terrain. Even so, in retrospect when analyzing the responses, surprises remained, meaning subconscious expectations existed.

**Hustling versus rushing.** Of interest was Kitty's perception in the scenario conveyed above that the hustling nurse was the one who listened and the one who was "slow-moving" was considered the one too busy or stressed to care. Others spoke of rushing/hurrying, being scattered, and distracted as behaviors that were labeled nonlistening and not rushing to get out/spending time as listening behaviors. At first this seemed like an oxymoron. But the idea of hustle aligned with such behaviors as good posture (versus slouching), sitting, and leaning in that showed an active interest in the patient's well-being. Perhaps the key to the interpretation was the follow-through related to the hustle, a code that has been subsumed under the theme of putting the patient at ease. If the fast movement was related to getting the job done, it was accepted. If, on the other hand, it conveyed disorganization, it was considered rushing—a negative behavior.

**Nature and frequency of nonlistening behaviors.** Florence Nightingale has written in her 1863 *Notes on Hospitals* that "it may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm" (Nightingale, 1863, p. iii). The same might be said for nurses, as they are part of that hospital environment and a profession known for caring. Negative sequelae developed when the patient perceived that the nurse was not listening. Patients were explicit about the many nurse behaviors that led them to believe nurses were not listening. These included rude responses, dismissing patient concerns, arguing with the patient, rejection of patient input, lack of eye contact, rolling the eyes, focusing on the computer instead of the patient, rushing, acting distracted or too busy, and not following through, among other behaviors. The number of behaviors ascribed to nonlistening was greater than expected, as was the emotion that recounting them evoked. As Thomas and Pollio (2002) found in their qualitative studies, "the psychological pain of being disbelieved and stigmatized is surely as devastating as…bodily pain" (p. 92). Beyond using numerical pain scales, as one example, it is also imperative to listen to the narrative behind the number.

**Acquiescence against better judgment.** Kitty, Ref, Karen, Arlene, and Carol: five very strong, competent, knowledgeable adults, three of whom are RNs. Seemingly, these five would have been the last participants to have succumbed to the nurse's abuse of power. And yet, they did. Even they, with all their knowledge and experience felt vulnerable and fearful. Kitty had always dismissed others' felt need to be an advocate for their hospitalized family members, even admitting she would think, "Oh, don't be a baby." But when she experienced the bullying herself, she shared, "…I kind of get this

now…. It makes you feel…vulnerable, and I didn't like that feeling at all." Ultimately, she acquiesced to taking a pill, to her own detriment, instead of the IV medicine she knew was ordered for her nausea, because she "felt a bit like, these people could hurt me." Recall, too, the response that Karen, a bioethicist, had to the nurse telling her to "suck it up." "I sucked it up at the time," she said, "because I felt it was just not appropriate, that I would write all this in my memory bank and then…I would come back because I really wanted to not put anyone on the defensive." Arlene just waited for the next shift, saying she just "wasn't in a position" to complain. She continued, "But listen, daylight is coming…so why make a fuss?" They all became compliant and submissive after initial attempts to make their case and, to a person, all labeled themselves a "good patient," someone who was uncomplaining, undemanding, and did not abuse the call light. Such strategies were aimed at avoiding further negative attention and not putting themselves in an even more vulnerable position.

Other unexpected findings included the following less-frequently mentioned behaviors:

- "Not interrupting" was only mentioned by one participant as a listening behavior
- Listening to, and then overriding, the patient's wishes was viewed positively
- A distinction was made between corporate and nursing actions as causes of problems encountered by the patients (such as nurse busyness, culture, or dearth of resources)

- Two participants, both men, identified silence as a nonverbal form of listening (Whether the behavior was not seen by others and so not identified, or whether it did not register in their mind as a listening behavior is not known)
- Listening behaviors not always mirrored by nonlistening behaviors (this may be because the participants witnessed the one but not the other, because the listening and the nonlistening behaviors were always assigned to two different nurses)

**Expected Findings**

The following section has addressed results that were not surprising. That they were not surprising has highlighted the inability of humans to completely bracket previous experiences as they framed present circumstances and new information. Though not surprising, they were, however, important to highlight, as likely not every reader might expect them.

**Caring linked with listening.** Caring was linked with listening (either as precursor or an outcome) as discussed above. This concept was borne out in the literature presented in chapter 2 and again in Chapter 5. It was validated by this study in which participants often tied caring to listening at times by defining listening as caring. For example, participants made the following supporting statements when asked about listening behaviors:

- (By listening), she seemed like she had my care at the forefront
- Listening is how much a person really cares about the conversation
- She cared about what I was saying and went and followed through on it
- She got personal, so she cared

- I think listening happens first, and then the touching and caring and the understanding comes after

Caring was not a task, something to be done to or for the patient, along with the morning assessment. Caring was something co-created and negotiated in interaction with the person, a coordinated dance between two human beings in a specific relationship. The patient must teach the nurse how to care, and the nurse must listen—not only to the patient's words but to his or her unspoken bodily response. (Thomas & Pollio, 2002, p. 6)

The key was making the nurse's behavior count so that the patient knew the nurse was listening. In other words, nurses need to be intentional about their behaviors.

**Patient vulnerability.** Another expected finding was that the more vulnerable the patient, the greater were the issues and the more negative were the comments related to perceived nonlistening. The phenomenon of patient vulnerability and its link to patient experience was well-substantiated in a study very similar to this. Irurita (1999) discovered that vulnerability was the one shared value, the core problem, related to patient perspectives regarding gaps in quality of care. Vulnerability was defined as the degree to which patients were prone to "physical and/or emotional hurt, harm, or injury…" related to both the life situation as well as their integrity (p. 11). Integrity was used to mean having a degree of control over circumstances, respecting human dignity, and being an individual, among other attributes.

When the patients had less control (e.g., needed help with the activities of daily living, like Neon did), were treated in a way that their self-respect was not valued (e.g., made to wait for over an hour while believing they were sitting in liquid stool, like Carol was), or treated in a manner that was one-size-fits-all (like Tarek), it is not hard to

imagine the greater degree of anger, humiliation, or fear. These types of situations led the patients to long for an advocate, especially when they were medicated and did not trust themselves to make their requests clear or were too tired or intimidated to fight for what they needed. When the nurse can find ways to increase patients' control of their situation, they help to reduce patient vulnerability (Irurita, 1999). One of the best ways to do that has been through establishing effective connection and nursing presence and using therapeutic touch, empathy, and compassion.

**Meeting needs.** In "real" life, as in an acute care setting, people have felt heard when their requests were acknowledged and fulfilled. The timeliness of that fulfillment was one of the response characteristics this study's participants linked to listening, including, but not primarily, answering the call light. As noted above, most patients felt they were "good patients" and did not use their call lights unduly. However, when they did need help, it was usually urgent and almost always had to do with the need to use the bathroom, with pain, nausea, or an empty IV bag. Island Girl set a low bar for timely responses when she said, "I didn't wait an hour; if I had to wait an hour then I'm thinking, 'They're not listening to me.' But, you know, a quick response and then…" Most patients needed a response sooner than an hour.

All patients preferred the nurse to be proactive, so they wouldn't have to bother her or him. Mickey was surprised that there "wasn't anything [she] needed at any point in time." She added, "when I had to call, they were right there. They answered me right away." But what she most appreciated was that "nobody complained once," because she was calling them so often and could not get up by herself. "I was drinking a ton of water, and I felt bad." The fact that no one complained increased her feeling of control,

decreased her feeling of vulnerability, and made her less likely to try to mobilize by herself—an action that would have put her safety at risk.

Another component of meeting the patient's needs was finding an alternative if the need could not be met as expected for some reason. No participant gave an example of doing this. Instead, it was only mentioned when the nurses failed to do so. Those who mentioned it were angry that the person on whom they were forced to depend would not try to find a solution that worked, even when the patient suggested one. Over one quarter of participants had this experience.

**Sitting conveys listening.** Nurses sitting at least once during the shift helped to make the human connection and suggested they are listening. Having found this to be true in my own practice, it was not a surprise when patients recognized it as a listening behavior. Riemen (1998) noted that patients wanted to have interactions with care providers who were interested in them, who were willing to sit with them and spend time listening to their concerns. The length of time or number of times spent sitting was irrelevant. Instead, it was the initial gesture, the proximity, and the intentionality of the face to face interaction that participants considered important.

The idea of proximity was addressed when King (1981) discussed personal systems and their application to nursing. She noted that "use of space and defense of space is nonverbal communication. The change in distance between people as they interact tends to communicate different messages to different people" (p. 38). In this study, proximity, along with other forms of body language such as sitting and leaning in, was described by 10 participants as part of a welcomed, listening posture, whereas standing at a distance was described by Diane as a nonlistening, even hostile, behavior.

Although proximity sometimes has been considered rude or imposing in the "real" world, when one is vulnerable and in need of reassurance, this use of space can be a valuable nonverbal communication tool. Indeed, King (1981) confirmed that "an individual's personal space is altered from one situation to another" (p. 37).

**Focus on computers as a source of patient irritation.** Many participants mentioned the impact the electronic health record had on their stay. Calling it "the computer," they railed against it as the thing that kept nurses from making the personal connection with them. Whereas patients understood the need to document, what they really wanted was for the focus to be on them first, then the computer. In a study on patient perception of technology use at the bedside, one patient was quoted as saying,

> As patients, we only want nurses to be nice to us, or to be tender in caring for us. That's it. That's what they should do, and this is all we want. As to what tools or devices they use, from my point of view as a patient, it's not that important. (Lee, 2007, p. 109)

In this study, Neon shared this scenario, speaking of a nurse she did not feel was caring. "She would not look at me. She looked away. And she was more concerned about her computer and putting the right stuff in the computer." Neon continued, "she'd go straight to the computer next to my bed and not even look at me, not even check on me…nothing." As necessary as the bedside computer is, it cannot be the nurse's primary focus. It is a means to an end, not *the* end.

## Study Rationale Support

In Chapter 1, rationales for undertaking the study were highlighted and discussed. They encompassed five areas relevant to nursing. After completing the study, another

literature search was undertaken to determine whether they were, indeed, reasonable and well-chosen. Findings supported each of them.

**Clinical Rationale**

After a years-long search of the literature, this study seems to have been the first to address specific nurse behaviors related to patient perceptions of listening. Even outcomes from listening, discussed in the literature, were not in an in-patient setting nor were they specific to nurses. One of the participants, Karen, worked where she received her care—and had a bad experience over 19 days. Because she was able to do so, she returned to the unit where she had so many problems and used the experience as a teaching experience. The nurses were shocked to get the feedback; they had no idea how their behaviors were perceived. Nursing management was able to use Karen's constructive feedback and nuanced perceptions to improve the care on that nursing unit and beyond. The expectation is that clinical nurses and nurse managers will be able to use what has been discovered in this study to do the same.

**Ethical Rationale**

Because nursing is a profession, it has been based on a foundation of ethics, codified in the ANA Code of Ethics with Interpretive Statements (ANA, 2015a) and in its Standards of Practice (2015b). Listening is an ethical mandate. By listening, nurses (a) help to preserve patient autonomy and dignity (see narratives by Carol and Ref); (b) include both patient and their family as part of the healthcare team (read Lily and Tarek stories); (c) help patients make informed decisions (see Ref and Diane's accounts); and (d) maintain a therapeutic nurse-patient relationship (see Kitty's and Neon's description; ANA, 2010b). Florence Nightingale addressed nurse presence, as described by Karen,

and related it to listening. This study's patient accounts can help nurses fulfill our ethical mandate as we adopt the behaviors they have identified.

**Financial Rationale**

As discussed above, hospitals have had a financial incentive to maintain patient experience scores that rival competitors' hospitals. Nurse communication, of which listening is a part, can help them do that. Kitty shared that she had gone to a certain hospital due to its reputation for nursing care. She was sorely disappointed and thus questioned whether she would return. The same was true for Carol, who told her doctor she would not return after her negative experience with nurses who did not listen. Participants also shared their increased willingness to partner with their healthcare team in following the prescribed plan of care after discharge. This could lower recidivism rates and obviate subsequent nonreimbursed charges.

**Educational Rationale**

Van der Elst et al. (2013) observed that the nurse-patient relationship was the one that most affected patient perception of an individual nurse and the nature of that relationship. The nurse-patient relationship has been essential in fulfilling the nurse's role as defined by the California Board of Registered Nursing (BRN): to "help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems, or the treatment thereof…" (California Board of Registered Nursing, 2013). Nurses cannot be wholly effective if they do not have a therapeutic relationship established with the patient. The study's participants were clear that this was a top priority for them, coded as Making a Connection. Because these behaviors now have been defined, they can be taught. Hence, the results should be of interest to clinical

and academic educators. As King (1981) noted, "knowledge of role and selected role concepts are essential in the education of individuals for professional nursing" (p. 90). Listening surely is one of those concepts.

### Spiritual Rationale

The role of pastoral care is within the nurse's purview as it includes nonreligious as well as religious forms of support. As mentioned in Chapter 1, Schnapp (2008) has noted that "the practice of pastoral care rests on listening effectively" (p. 136). The nurse is in a perfect position to fulfill that role. The behaviors associated with pastoral-level listening included many of the behaviors the participants mentioned: presence, mindfulness, responsiveness, and "the skills of therapeutic and empathic listening" (Schnapp, 2008). Note that these are skills, and skills can be taught. Nurses need not be religious practitioners to be the spiritual support that the patient needs. Carol, who was Jewish, felt supported and relieved to have her non-Jewish nurses pray for and with her. Most of the participants mentioned caring or empathy as a listening behavior and the outcomes were improved because of it. A need for awareness of patient body language was conveyed by Holly and Diane, among others.

## Advice for Nurses: Takeaways from the Participants

As shared above in Chapter 4, participants gave advice to nurses about the things they felt nurses should know about listening. To summarize those insights, a trust-enabled dynamic between nurse and patient provided the opportunity for the patient to feel safe in being candid and for the nurse to get the information needed to better fulfill the professional role in service to the patient in a holistic way. Alternatively, when a collaborative relationship was not established, the sequelae ranged from mildly annoying

to harmful. These subjective findings showed the benefits of collaborating with patients to respect their autonomy and to assure them that they have control of their care, to whatever degree that is possible. Said findings also have given insight into how nurses can, through listening skills, convey the connection needed to establish such a relationship.

## Study Strengths

One of the greatest strengths of this study was the way my almost 40 years of nursing and meeting facilitation and training allowed me to have a deep well of listening experience from which to draw. This experience allowed me to perceive patient meanings and hesitancies, and to draw out unexpected results. My ability to quickly connect with the patients and establish trust led to answers that were unguarded and compelling. Additionally, it has been the first study to formally determine the ways in which patients perceived and defined nurse listening behaviors. Heretofore, the need for nurses to listen to their patients was accepted dogma, but no data from the patients' perspective was available on how to act to ensure its perception. Because of the way this study was conducted—using the semi-structured interview—all the research questions were well-answered, and the patient experience was richly described. The use of IPA as a methodology established a way for this study to be easily replicated. Procedural and analytical rigor were ensured; potential biases were confronted; questions and probes were vetted; and, codes and themes were endorsed by the participants, reinforcing credibility. And, finally, this study also simultaneously supported and adapted a middle-range nursing theory. Results are practical and can be acted on and taught.

## Study Limitations

This study was limited to adults over 50 years of age with a non-psychological diagnosis who had recently received medical or surgical care in an acute care setting. Such restrictions, although necessary for clarity, and desirable in qualitative research, also were limiting in terms of the ultimate transferability of the results to the broader population of all adult acute-care inpatients or to an outpatient setting. Also, of necessity, limiting the formal catchment area to Southern California posed confines on such variables as nurse demographics, nurses' educational preparation (e.g., greater number of nurses with two-year associate's versus bachelor's degrees than in other parts of the country), and nurse-patient ratios that differed from those in other geographic locales, potentially limiting the usefulness of the results in other contexts. Finally, some ethnicities were under-represented in the sample when compared to the general population, especially that of California. More diverse participant cultural representation would have enhanced the transferability of this study.

## Implications for Nursing

Besides having the potential, if used, to greatly benefit patients, the knowledge garnered from this study is significant to nursing education, practice, administration, ethics, and theory development.

### Education

The listening nurse behaviors elucidated by the patients can, and should, be taught, beginning in the first semester of nursing school (whether in an associate or a bachelor's degree program) and integrated into the curriculum throughout the formal educational journey. As suggested by Thomas and Pollio (2002), "Students must be

encouraged to reflect on their own prior experiences and on their daily interactions with patients" (p. 255). This self-reflection should be assigned in relation to the intentional practice of listening behaviors.

**Practice**

For those nurses currently practicing, it is never too late to be made aware of and to adopt therapeutic behaviors, just as it is never too late to stop using untherapeutic ones. They need to clarify that listening occurred by encouraging patient feedback and candor. However, changing behavior requires awareness and accountability. Site educators should be aware of these data and use them as a foundation for every class they teach or in-service they give.

**Administration**

Listening behaviors should be intentional in the practice environment and nursing administrators or managers can support such a directive. Although "no one can mandate that anyone care or engage in caring practices…. nursing administrators…can create working environments and climates that facilitate caring practices" (Benner, 2001, p. vii). Listening is one of those practices that should be intentionally supported by the work environment, and this expectation can be set by management.

**Ethics**

Ethically speaking, a few participants mentioned that their nurses were distracted or seemed to have brought their personal problems with them to work. Nurses are human beings, after all. However, as acknowledged by Thomas and Pollio (2002), "there is a moral imperative for each individual practicing nurse to attempt to humanize inhumane treatment settings, clear the debris of his or her own personal and professional life

turmoil and pain, and prepare to meet the patient—unencumbered, ready to engage in dialogue," (p. 254). This moral imperative has, at its core, listening. Knowing how patients perceive nurse behaviors, nurse managers and nurses themselves can learn from these results and change both their behaviors and the environment that supports the practice of the behaviors, including accountability for their use.

### Theory Development

The results of this study have shown the way in which perception sets the stage for the rest of the journey toward goal attainment. This study also showed how it is possible to frame a study around one theory just to end up discovering another. Discovery needs to continue to validate, refute, recommend, and test new, additional, and alternative theories, including the one suggested by these results, providing empirical results for further testing and generalizability.

## Recommendation for Future Research

Because this has appeared to be the first study on this subject, possibilities for future research are many. Because this study was limited to certain ages in specific geographic areas, future studies could easily address both limitations. Adults under 50 years of age or in a certain portion of the 21-49-year-old bracket could be interviewed. Adults outside Southern California would be another obvious group to consider for continued qualitative research. Another option would be to create a quantitative instrument with these data and pilot it with participants like those in the first group to endorse the current findings. The initial pilot of any instrument could include a section for qualitative narrative, or a mixed methods study could be conducted.

Additionally, because listening is a universal concept, future research need not be

limited by geography or setting. Hence, studying a population from an outpatient setting is also recommended.

## Conclusion

The way human beings "know" one another is through listening. As demonstrated in this study, it has seemed to be so deeply embedded within us that we may have a difficult time quantifying or identifying the behaviors that drive our perceptions. With time and prompts, however, most can describe these behaviors, at least to some degree. Nonlistening behaviors seemed easiest to recall and define and women seemed to be able to identify and describe more easily.

Most patients equated listening with caring. Caring was the precursor or impetus to listening. Thus, caring was the motivation and listening was the manifestation of the caring. Ultimately and generally, in life, feeling cared for is important. To someone in a position of vulnerability (e.g., a hospitalized patient), that caring (or at least the perception of caring) can become paramount to the experience and to overall well-being, both in and beyond the hospital.

As this study has shown and research has suggested, patients have wanted and needed to be heard. And, they have wanted to be "good" patients, not bothering the nurse in what they knew was a hectic routine of juggling multiple patients' needs. They also have wanted to have their self-knowledge respected and incorporated into the plan of care. Mostly, they have desired the nurse's full attention for whatever time they are together, however brief that may have been. They have thrived when the connection was made early in the relationship.

Nurses need to be aware of how their behaviors are perceived. They then need to

be intentional about making a connection and conveying a readiness to partner with and care about the patient. Patients' well-being and safety depend upon it.

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# APPENDIX A

# TARGET POPULATION DEMOGRAPHICS

| | Demographic Snapshot of Americans age ≥ 50 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **%** | 0-10 | 11-20 | 21-30 | 31-40 | 41-50 | 51-60 | 61-70 | 71-80 | 81-100 |
| Female | | | | | | x | | | |
| Race | | | | | | | | | |
| White | | | | | | | x | | |
| Black | x | | | | | | | | |
| Hispanic | x | | | | | | | | |
| Education | | | | | | | | | |
| < HS | | x | | | | | | | |
| HS grad | | | | x | | | | | |
| Some college | | | x | | | | | | |
| College or > | | | x | | | | | | |
| Marital status | | | | | | | | | |
| Married | | | | | | x | | | |
| Divorced | | x | | | | | | | |
| Widowed | | x | | | | | | | |
| Never married | x | | | | | | | | |
| Separated | x | | | | | | | | |
| Work Status | | | | | | | | | |
| Unemployed | | | | | | x | | | |
| Employed | | | | | x | | | | |
| Finances | | | | | | | | | |
| > $75K/yr | | | | x | | | | | |
| < $10K/yr | x | | | | | | | | |
| Health insurance | | | | | | | | | |
| 50-64 w/o | x | | | | | | | | |
| >50 - primary Medicare | | | | | x | | | | |
| Health | | | | | | | | | |
| ED last 3y | | | | x | | | | | |
| BP | | | | | x | | | | |
| Allergies | | | x | | | | | | |
| Virus | | | x | | | | | | |
| Cholesterol | | | x | | | | | | |
| Arthritis | | x | | | | | | | |
| “Control own health” | | | | | | x | | | |

# APPENDIX B

# FACTS ABOUT OLDER AMERICANS

- Many more current older adults will live past 90 or 95 years of age
- The over-85 age group is growing faster than any other age group
- 85% of American adults over 100 years of age are women
- Almost half of women over 75 years of age live alone
- Older women are more than twice as likely as older men to live in poverty; non-white elders are more likely than their white counterparts to live in poverty
- More elderly will be culturally diverse in the coming decades (with the greatest increase being among Latinos)
- Of those older adults with a grandchild living in their home, one quarter of them are the primary caregivers
- Between two and four million older adults identify as lesbian, gay, bisexual, or transgender
- Most older adults are not impaired by the common, mild, age-associated changes in cognition
- While adding new skills may take longer, older adults are still capable
- As a group, older adults report fewer mental health problems than those of other groups; however, 25% experience such issues as "depression, anxiety, schizophrenia, or dementia" (p. 2)
- The highest suicide rate for any age group or gender is for men over 85
- Substance abuse in this age group is increasing rapidly
- Chronic conditions affect approximately 92% of those over 65; 77% have two or more.
- Two thirds of deaths for those over 65 years are caused by "heart disease, cancer, stroke, and diabetes" (p. 2)—all chronic conditions
- Those over 55 represent 25% of those living with human immunodeficiency virus (HIV)
- Hearing loss is common but often not severe
- Vision loss causes difficulty driving at night, reading quickly, reading small print, or reading in dim light
- Once over 85 years of age, the need for help with activities of daily living increases significantly (40% of men and 53% of women up from approximately 20% between 65 and 74 years old)
- Those in ethnic and racial minority groups are much more likely than their White counterparts to be living with diabetes, hypertension, and other chronic illnesses
- Only approximately 5% of older Americans live in nursing homes
- Many older Americans maintain both physical and emotional intimacy
- Alzheimer's disease risk can be mitigated by maintenance of a healthy lifestyle (APA, 2018).

American Psychological Association (APA). (2018). Older adults' health and age-related changes: Reality versus myth. Retrieved April 2, 2018, from www.apa.org/pi/aging/resources/guides/older.aspx

# APPENDIX C

# RECRUITMENT LETTER

RECRUITMENT FLYER

Adult Patient Perceptions of Nurse Listening Behaviors: A Qualitative Study

# ATTENTION: ADULTS WHO HAVE RECENTLY BEEN A PATIENT IN A HOSPITAL

HELLO! I am a nurse conducting a research study as part of the requirements for obtaining a Doctor of Philosophy degree (PhD) at Azusa Pacific University. I am looking at the way adult patients interpret nurses' behaviors. The focus of the study will be to learn (a) which nurse behaviors implied listening, (b) which, if any, implied that the nurse did not listen, and (c) whether listening or not listening had an effect during or after your hospital stay.

I would like to meet with you and give you an opportunity to share your experience of being a patient who had a nurse who you feel listened and/or one who you feel did not listen to you.

You are eligible to participate in my study if you:

- are ≥ 50 years of age
- have recently been in a hospital on a medical or surgical unit
- speak English
- are willing and able to share your experience with me for 1-1.5 hours in person
- are willing to be audio-recorded (which will remain confidential)
- have not had a diagnosis of any disease affecting the memory (such as Alzheimer's or dementia)

You are provided this letter by one of the nurse managers at this hospital because of your eligibility to participate in this study.

As the researcher, I do not have any information about you. I will only know who you are if *you* decide to contact *me* to either participate or just to find out more about the study. Seeking information about the study or agreeing to be contacted does not obligate you to participate in the study. No hospital staff will know if you respond to this letter. Therefore, if you do not respond to this letter, no further contact will be made.

Although there would be no direct benefit to you from participating in this study beyond having your voice heard, increasing our understanding of patient perceptions of nurses' behaviors could help many future patients. Thank you very kindly for considering the opportunity to be part of this discovery process.

If you would like additional information about this study, please call me at [redacted] or email me at [redacted] THANK YOU! Nancy

**Nancy Loos, PhD(c), MSN, RN, PHN, NE-BC**
**Azusa Pacific University School of Nursing** [redacted]

## APPENDIX D

## PATIENT DEMOGRAPHIC DATA COLLECTION SHEET

Thank you for agreeing to participate in this study of patient perceptions of nurse listening behaviors. Of interest is whether different personal factors in the patients (such as age, gender, marital status, etc.) makes a difference in how these nurse behaviors are seen. To that end, you are being asked to complete the following demographic questionnaire before we begin the interview session.

1. Sex: Male/Female: _____
2. What is your age*? _____
3. What is your ethnicity? _____
4. To which culture to you most relate? _____
5. What is your marital status? _____
6. How many years of education did you complete? _____
7. What is/was your profession/vocation? _____
8. During your most recent hospital stay, how many days did you spend in the hospital? _____ days
9. How many days has it been since you were discharged from your most recent inpatient hospital stay? _____ days
10. Why were you in the hospital?
    _____

*Any age >90 will be coded as "90"

## APPENDIX E

## PRESCREENING INCLUSION/EXCLUSION SCRIPT

1. *Hello and thank you for responding to my recruitment letter*.

2. *Would be willing to answer some questions to determine your eligibility to participate in this study?*

3. Scenario: If the participant is on the phone and prefers to meet in person, an appointment will be made to meet with the participant based on their convenience.

4. *Please answer the following questions to the best of your ability*:
   (NOTE: English fluency can be determined during the screening interview)
   a. *Are you over 50 years of age?*
   b. *Have you been a patient in a hospital within the last 6 months for any reason?*
   c. *Do you live in Southern California?*
   d. *Are you willing to participate in this study?*
   e. *Are you willing to have the interview be audio recorded?*
   f. *Are you able to tolerate sitting and conversing for 1 to 1.5 hours?*
   g. *Have you been told by a health care professional that you have any disease that affects your memory such as Alzheimer or Dementia?*

5. Scenario A: If the participant **does not meet** initial eligibility or the person is not interested in participating in the study: either:
   a. *I am sorry, but your situation does not meet the eligibility criteria for inclusion in this study*, or
   b. *I understand that you have chosen not to participate in this study.*
   *This interview record will now have any identifiable information removed so no one can link you to this study*.

6. Scenario B: If the participant **appears to be eligible** and is interested in pursuing the study, they will be asked to
   a. provide contact/identifying information (e.g. last name, address, birth date, telephone #, date of discharge from the hospital, and diagnosis).
   b. Either meet in person to sign the consent or, if geographically distant, sign the consent (which will be emailed, faxed, or mailed to the participant) and mail or fax the document to the study team.

If the participant qualifies for the study based on responses noted on the prescreening document and signs the informed consent, then the pre-screening document will be kept in the participant's research chart.

# APPENDIX F

# ORIGINAL RECRUITMENT FACILITY DEMOGRAPHICS

| RECRUITMENT FACILITY DEMOGRAPHICS | | | | |
|---|---|---|---|---|
| | **Hospital A** | **Hospital B** | **Hospital C** | **Hospital D** |
| Location | **Mid-San Fernando Valley** | **North San Fernando Valley** | **SW San Bernardino City** | **Santa Clarita Valley** |
| Category | General Medical/Surgical | General Medical/Surgical | General Medical/Surgical | General Medical/Surgical |
| Magnet Status | N | Y | N | Y |
| Trauma: Adult/Pediatric | Y/Y | Y/N | Y/Y | Y/N |
| ICU: Neonatal/Pediatric | Y/Y | Y/Y | N/N | Y/N |
| Inpatient Psychiatric Unit | Y | N | N | Y |
| Inpatient Rehab Unit | Y | Y | N | Y |
| Disproport. Share Hospital* | N | Y | N | N |
| Staffed beds/patient days | 424/54,200 | 377/77,129 | 445/95,943 | 238/52,983 |
| Average Length of Stay (in days) | 4.36 | 4.42 | 4.39 | 4.35 |
| Nursing staffing (USNews) | Excellent | Excellent | Excellent | Excellent |
| Bargaining Unit Representation | Y | N | N | N |
| Pt Exp (Medicare/ USNews) | 2 on scale of 5 | 3 on scale of 5 | 3 on scale of 5 | 3 on a scale of 5 |
| Teaching Hospital/# of residents | Y/24 | N/0 | Y/305 | N/0 |

*Disproportionate Share Hospital (DSH) adjustment payments provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients; eligible hospitals are referred to as DSH hospitals. (Office of Statewide Health Planning and Development [OSHPD], 2014, map 1)

Data taken March 30, 2018 from: https://www.ahd.com/states/hospital_CA.html
https://health.usnews.com/best-hospitals/search
https://www.medicare.gov/hospitalcompare/About/HCAHPS-Star-Ratings.html

# APPENDIX G

# CALIFORNIA NURSING WORKFORCE DEMOGRAPHICS

- Each 10-year age range (e.g., 25-34, 35-44, etc.) through age 64 are equally represented as a percentage of the nursing workforce (p. 27)

- Females represent 87.9% of the workforce (p. 29)

- White, non-Hispanic nurses = 49.8%, followed by Filipino nurses at 17.6% (p. 29)

- Tagalog and Spanish (19.1% and 10.7%) are the most commonly spoken non-English languages by California RNs (p. 33)

- Married RNs represent 67.4% of the population (p. 34)

- In 2016, the highest education by percentage of RNs residing in California is a baccalaureate (BSN) degree (48.3%). Those with Associate of Arts (AA) degrees make up 37.8%. By age, the youngest cohort—those under 35 years—has the highest percentage of BSNs at 60.9%, reflecting a decades-long trend (p. 43)

- RNs who do not have certifications conveyed by the BRN is 76.5%; the most common certification conferred is that of Public Health Nurse (PHN) at 17.5% (p. 44)

- Those RNs with active California licenses residing in California are more likely to have less than 10 or more than 35 years of experience (39% and 13%, respectively) (p. 46)

- The majority (approximately 60%) of employed RNs work between 33 and 40 hours per week (p. 47)

Data retrieved from the article by Spetz, Chu, Jura, & Miller (2016)

## APPENDIX H

## INFORMED CONSENT

AZUSA PACIFIC UNIVERSITY

Adult Patient Perception of Nurse Listening Behavior: A Qualitative Study
Nancy Loos, MSN, RN, NE-BC
IRB # 18-153

## *2017-18* INFORMED CONSENT FORM

**Voluntary Status:** You are being invited to participate in a research study conducted by the researchers listed above. You are being asked to volunteer since you meet the requirements for enrollment into this study. Your participation is voluntary which means you can choose whether or not you want to participate. You may withdraw any time without penalty. If you decline to continue, any data gathered to that point will not be used in data analysis. If you choose not to participate, there will be no loss of benefits to which you are entitled. Before you can make your decision, you will need to know what the study is about, the possible risks and benefits of being in this study, and what you will have to do in this study. The research team is going to talk to you about the study, and they will give you this consent form to read. You may also decide to discuss it with your family or friends. If you find some of the language difficult to understand, please ask the researcher and/or the research team about this form. If you decide to participate, you will be asked to sign this form.

**Purpose:** The study in which you are being asked to participate is designed to obtain your perceptions of behaviors exhibited by the nurse during a recent hospitalization. Specifically, the purpose is to understand which behaviors made you believe the nurse listened (or didn't listen) to you. Because little can be found in existing literature that describes these behaviors, it is important to know from the patient point of view whether specific nurse actions convey listening or whether they convey not listening.

**Procedure:** To be a voluntary participant in this study, you will be asked to spend about one to one and a half hours with the researcher in a quiet setting in which you will be comfortable. In this interview, you will be asked to answer open-ended questions about your experience and give your recollection of ways in which the nurse behaved that made you perceive the interaction the way you did. You will be asked to be audio recorded during the interview, so the researcher can focus on listening to your experience.

**Commitment and Compensation:** Your total participation in the study will take approximately 1-2 hours over 1-2 sessions. Each session will last approximately 1-1.5 hours. As a way of saying thank you, you will receive a $25 coffee card.

**Possible Risks & Benefits:** It is expected that participation in this study will provide you with no more than minimal risk or discomfort which means that you should not experience it as any more troubling than your normal daily life. However, there is always the chance that there are some unexpected risks. These may include, for example, an accidental disclosure of your private information, or discomfort by answering questions

that are embarrassing. If you feel uncomfortable or distressed, please tell the researcher and she will ask you if you want to continue. Because this is research and does not have anything to do with the current services you are receiving, you can withdraw from the study at any time without penalty.

No- or low-cost mental health resources are available to assist you should you need them. Please see separate page for options in your area.

You will not receive any direct (non-monetary) benefits from participating in this study; however, your participation in this study will help improve the knowledge about nurse listening behaviors, which can be used as feedback to nurses to reinforce or change their behavior. Your participation may, in the future, benefit other people who have also been hospitalized.

**Confidentiality & Consent:** The investigator and staff involved with the study will keep your personal information collected for the study strictly confidential. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. Your identity will be kept strictly confidential by separating your name from your answers and substituting your name with a number on the actual notes; only the researcher will be able to link the two. Your data and the identification key will be kept separately in areas that are double locked. No one else will have access to the notes, which will be destroyed at the completion of the study.

This document explains your rights as a research subject. If you have questions regarding your participation in this research study or have any questions about your rights as a research subject, please contact the Principal Investigator using the information at the bottom of this form. Concerning your rights or treatment as a research subject, you may contact the Research Integrity Officer at Azusa Pacific University (APU) at (626) 812-3034 or at dguido@apu.edu.

**Conflict of Interest:** The Principal Investigator has complied with the Azusa Pacific University Conflict of Interest in Research policy.

**Consent:** I understand that my participation in this study is entirely voluntary and that I may refuse to participate or may withdraw from the study at any time without penalty. I understand the procedures described above, and I understand fully the rights of a potential subject in a research study involving people as subjects. My questions have been answered to my satisfaction. I agree to participate in this study. I have received a copy of this consent form.

□ I agree to be audio taped □ I do not agree to be audio taped

| _____ | _____ | _____ |
|---|---|---|
| Participant Name Printed | Participant Name Signed | Date |

I have explained the research to the subject or his/her legal representative and answered all of his/her questions. I believe he/she understands the information described in this document and freely consents to participate.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Principal Investigator | Date | Time |

[Signed by researcher after participant has demonstrated understanding of research procedures through questions and answers]

Nancy Loos, [redacted]

# APPENDIX I

# NO-COST AND LOW-COST RESOURCES

## NO-COST AND LOW-COST RESOURCES

### In the San Fernando Valley (Los Angeles County)

- **Los Angeles County/Olive View: Community Mental Health Center**
  Provides crisis intervention, medication support, mental health services (MHS), psychological testing, targeted case management services
  **Location:** 14659 Olive View Dr., Sylmar, Ca 91342
  **Hours:** Mon - Fri 8:00 AM - 10:00 PM; Sat & Sun 9:00 AM - 5:30 PM

- **Olive View Community Mental Health Urgent Care Center**
  Provides consumers with a place to get a brief clinical assessment, immediate case management, medication refills, acute mental health care, crisis intervention services, assistance with ongoing services for consumers, etc.
  **Location:** 14659 Olive View Dr, Sylmar, CA 91342
  **Hours**: Open seven days a week (24/7)
  **Phone**: (800) 854-7771

- **Los Angeles County Adult System of Care information line:**
  **PHONE:** (213) 738-2868 between the hours of 8:00AM and 5:00PM, Monday through Friday.
  **AFTER HOURS:** Call the ACCESS Center 24/7 Helpline at 1-800-854-7771.

### In San Bernardino County

- **NAMI (National Alliance on Mental Illness) HelpLine:**
  **1-800-950-NAMI (6264)**

  The NAMI HelpLine can be reached:
  Monday through Friday, 7 am–3 pm, Pacific Time.
  Or TEXT NAMI TO: 741741
  or info@nami.org

- **Local Resources:**

  Department of Behavioral Health Access Unit - Crisis Referrals 24/7
  1-888-743-1478

- **Crisis Walk in Centers (CWIC)**
  The Crisis Walk-In Center is a much-needed location for county residents who are in need of emergency psychiatric services.
  The CWICs conducts psychiatric assessment and crisis stabilization for those clients who are in acute psychiatric distress or are a danger to themselves or others or gravely disabled. The walk-in crisis clinics provide a care alternative that enables individuals to be treated and stabilized in their community.

- **CWIC Rialto:** (Monday thru Friday: 8 am - 10 pm…Saturday: 8 am - 5 pm…Closed Sundays)
  850 East Foothill Blvd.
  Rialto, CA 92376
  (909) 421-9495

- **CWIC High Desert** (Open 24 hours a day, 7 days a week)
  12240 Hesperia Rd.
  Victorville, CA 92395
  (760) 245-8837

- **CWIC Morongo Basin (**Open 24 hours a day, 7 days a week)
  7293 Dumosa Ave., Suite 2
  Yucca Valley, CA 92284
  (855) 365-6558

- **Community Crisis Response Team (CCRT)**
  CCRT is a community-based mobile crisis team that provides assistance to those who are experiencing a mental health related emergency.
  Services include: Mental Health Assessments.
  Relapse Prevention.
  Intensive Follow Up Services.
  On-site Crisis Intervention.
  **Teams are available 24 hours a Day, 365 Days per Year**

  - **West Valley:** Covering Fontana to Chino Hills.
    Office: (909) 458-1517 Pager: (909) 535-1316

  - **East Valley:** Covering Yucaipa, Redlands, Loma Linda, Colton, San Bernardino, Bloomington, East Fontana.
    Office: (909) 421-9233 Pager: (909) 420-0560

  - **High Desert:** Covering Victorville, Hesperia, Apple Valley, Phelan, Adelanto, Lucerne Valley, Barstow.
    Office: (760) 956-2345 Pager: (760) 734-8093

  - **Morongo Basin:** (760) 499-4429

  - **Community Crisis Services Administration**
    850 E. Foothill Blvd.
    Rialto, CA 92376
    Phone: (909) 873-4453

## APPENDIX J

## INSTRUMENT: SEMI-STRUCTURED INTERVIEW QUESTIONS

**Semi-structured Interview Questions for Adult Patient Perceptions of**

**Nurse Listening Behaviors in an Acute Care Setting**

1. **I have a few questions to ask you before we talk about your experience.**

   [PROBES: (Gender will be recorded). What is your age*? How would you describe your ethnicity? How would you define your culture? What is your marital status? Describe your level of education. What is/was your profession? On your recent hospital admission, how many days did you spend as an inpatient? How many days has it been since you have been discharged?] *all ages >90 will be coded as "90"

2. **What comes to mind when you hear the word "listen" or "listening"?**

3. **Consider your recent hospitalization and recollect a registered nurse (RN) who you believed listened to you. Can you please describe the setting and what the nurse did that made you feel he or she was listening?**

   [PROBES: Can you elaborate further? Were there any other signs, either verbal or non-verbal, that you can recall that made you feel this way? Did your family members feel the same way about this nurse?]

4. **Again, during your recent hospitalization, did you encounter an RN who you believed was not listening to you? Can you please describe the setting and what the nurse did that made you feel he or she was NOT listening?**

   [PROBES: Can you elaborate further? Were there any other signs, either verbal or non-verbal, that you can recall that made you feel this way about this nurse?]

5. **IN what way did the nurse's listening affect your experience or health in and beyond the hospital, if at all?**

   [PROBES: Before you left the hospital, were you aware of what you needed to do to continue recovering once you got home? Have you had any difficulties with your health since you have been home? How did the nurse's behavior make you feel?]

6. **In what way did the nurse's NOT listening affect your experience or health in and beyond the hospital, if at all?**

   [PROBES: Do you think this would be true for all patients, or is this just something you feel is important to you? How did this/these behavior(s) make you feel?]

7. **Is there anything you would like to tell nurses about listening to hospitalized patients? If so, what would it be?**

[PROBES, if not previously answered: Before you left the hospital, were you aware of what you needed to do to continue recovering once you got home? Have you had any difficulties with your health since you have been home and, if so, do you feel they are related in any way to nurse's listening behaviors?]

## APPENDIX K

## ADDITIONAL FACILITY DEMOGRAPHICS, PARTS A and B

| ADDITIONAL FACILITY DEMOGRAPHICS, PART A | | | | | | |
|---|---|---|---|---|---|---|
| | **Hospital E** | **Hospital F** | **Hospital G** | **Hospital H** | **Hospital I** | **Hospital J** |
| Location | **West-San Fernando Valley** | **L.A. West Side** | **South East Ventura County** | **L.A. West Side** | **East Ventura County** | **SW LA County** |
| Category | General Medical/ Surgical | General Medical/ Surgical | General Medical/ Surgical | General Medical/ Surgical | General Medical/ Surgical | General Medical/ Surgical |
| Magnet Status | N | N | N | Y | N | N |
| Trauma: Adult/Ped | N/N | N/N | Y/N | N/N | N/N | Y/N |
| ICU: Neonatal/ Pediatric | Y/N | Y/Y | Y/N | Y/N | Y/N | Y/N |
| Inpt Psych Unit/Rehb | N/N | Y/N | N/Y | N/N | N/N | N/Y |
| DSH | N | N | N | N | N | N |
| Staffed beds/patient days | 284<br>35,344 | 528<br>117,614 | 307<br>73,694 | 266<br>57,970 | 144<br>29,115 | 302<br>53,314 |
| Average Length of Stay (in days) | 3.34 | 4.96 | 4.83 | 4.70 | 4.07 | 4.94 |
| Nurse staffing (USNews) | High | Very High | High | Very High | Very High | High |
| Bargain Unit Rep | Y | Y | Y | N | N | Y |
| Pt Exp (Medicare /USNews) | 4 (of 5)<br>4 (of 5) | 3 (of 5)<br>3 (of 5) | 2 (of 5)<br>3 (of 5) | 3 (of 5)<br>3 (of 5) | 3 (of 5)<br>2 (of 5) | 2 (of 5)<br>2 (of 5) |
| Hosp Comp/ Overall Rating | 4 on scale of 5 | 3 on scale of 5 | 2 on scale of 5 | 4 on scale of 5 | 2 on scale of 5 | 2 on scale of 5 |
| Teaching Hospital/ # of residents | Y/18 | Y/210 | N/0 | N/0 | N/0 | Y/31 |

| ADDITIONAL FACILITY DEMOGRAPHICS, PART B | | | | | |
|---|---|---|---|---|---|
| | **Hospital K** | **Hospital L** | **Hospital M** | **Hospital N** | **Hospital O** |
| Location | **SW L.A. County** | **SW San Bernardino County** | **North Orange County** | **East San Fernando Valley** | **Mid/south San Fernando Valley** |
| Category | General Medical/ Surgical | General Medical/ Surgical | General Medical/ Surgical | General Medical/ Surgical | General Medical/ Surgical |
| Magnet Status | Y | N | N | N | N |
| Trauma: Adult/Peds | Y/Y | N/N | N/N | N/N | N/N |
| ICU: Neonatal/Peds | N/N | Y/Y | N/N | Y/N | Y/Y |
| In-pt Psych In-pt Rehab | N/Y | N/N | Y/N | N/Y | N/N |
| DSH | N | N | N | N | ? |
| Staffed beds Patient days | 453 96,631 | 626 136,744 | 219 25,033 | 393 73,296 | 245 56,555 |
| Avg LOS (days) | 5.05 | 4.34 | 4.25 | 4.38 | 4.2 |
| Nurse staffing (USNews) | Very High | Very High | High | Very High | Very High |
| Bargaining Unit Rep? | Y | Y | Y | Y | Y |
| Pt Exper. AHD/ USNews | 3 (of 5) 3 (of 5) | 3 (of 5) 3 (of 5) | 1 (of 5) 1 (of 5) | 3 (of 5) 3 (of 5) | 2 (of 5) 2 (of 5) |
| Hosp Comp Overall rating | 4 on scale of 5 | 3 on scale of 5 | 3 on scale of 5 | 1 on scale of 5 | 3 on scale of 5 |
| Teaching Hosp/ Resident FTEs | Y/71 | Y/81 | Y/30 | N | N |

## APPENDIX L

## PARTICIPANT DEMOGRAPHIC REPRESENTATION

| PARTICIPANT DEMOGRAPHIC REPRESENTATION | | | |
|---|---|---|---|
| **Demographic** | **Profession/Vocation** | **#** | **%** |
| **Culture most aligned with** | • American | 19 | 82.6 |
| | • White Hispanic | 1 | 4.3 |
| | • European | 1 | 4.3 |
| | • Arab/American hybrid | 1 | 4.3 |
| | • Mexican/American hybrid | 1 | 4.3 |
| **Profession** | • Professions: fire fighter, construction, graphic design, engineer, human resources (3) | 7 | 30 |
| | • Retired: some overlap with profession | 6 | 26 |
| | • Service/clerical: waitress, secretarial, support, guard | 6 | 26 |
| | • RN (either retired or working) | 4 | 17.4 |
| | • Educator/teacher | 3 | 13 |
| | • Healthcare (non-RN, including in management) | 3 | 13 |
| | • Management (non-healthcare) | 2 | 8.6 |
| | | 1 | 4.3 |
| **Days in hospital** | • 1-5 | 14 | 60.8 |
| | • 6-10 | 5 | 21.7 |
| | • 11-15 | 2 | 8.6 |
| | • 16-20 | 2 | 8.6 |
| **Days since discharge** | • ≤ 7 (4) | 1 | 4.3 |
| | • 8-25 (8, 13, 14, 15, 16, 20, 21) | 7 | 30 |
| | • 26-75 (28, 43, 54, 56, 60, 73) | 6 | 26 |
| | • 75-150 | 0 | 0 |
| | • 151-180 (159, 161, 164, 169, 171, 171, 175, 176, 180) | 9 | 39 |
| **Reason for hospitalization** | • Non-orthopedic surgical/procedures: hemi-thyroidectomy, benign brain tumor removal, pacemaker, colonoscopy sequelae, TAH, sigmoid colectomy, bowel resection, polyp removal, cancerous kidney removal | 9 | 39 |
| | • Medical: UTI, Gall bladder, pneumonia, full arrest, acute pancreatitis, anemia | 6 | 26 |
| | • Orthopedic surgeries: hip x2, shoulder/femur fracture/repair, pelvic screws, ORIF, spinal fusion | 6 | 26 |
| | • Neurologic: stroke | 2 | 8.6 |