Hospitalization for surgery or acute illness often presents as an interruption in the lives of those experiencing it at best and a crisis of extreme proportions at worst. Nurses have been at the forefront in guiding the patient through the course of illness toward recovery. For this research study, the investigators used anecdotal patient comments about positive nursing experiences from the Hospital Consumer Assessment of Healthcare Providers and Systems® 2015 survey to identify nurses who were perceived by patients as providing a positive care experience. The survey covers topics that are important to patients and focus on aspects of quality care such as the communication skills of providers and ease of access to health care services (Agency for Healthcare Research and Quality, 2015). In addition to providing quantitative data, the patients may provide qualitative information in the form of comments. In several instances, patients left comments with specific nurses’ names. The nurses identified by patients as providers of positive patient experiences were asked to participate in the study. The purpose of this study was to explore the nurse self-identified characteristics and behaviors that contribute to patients’ positive perceptions of their nursing care.

**Literature Review**

Researchers examining the relationship between nurse and patient, in a study of 210 nurse—patient dyads, uncovered that bonding between nurse and patient directly affects patient satisfaction (Tejero, 2012). A study of 105 trauma patients revealed that patients identified nurses as most caring when the nurses met the patients’ stated and unstated needs and exhibited confidence with the patients (Merrill, Hayes, Clukey, & Curtis, 2012). Researchers in a study of patient satisfaction and nurses’ caring behaviors with a sample of 1,565 patients in several European countries found that these behaviors were associated with patient satisfaction (Palese et al., 2011).

In a secondary analysis of patient care data from 396 hospitals and 16,241 nurses, researchers determined that nurses’ reports of excellent quality of

**Author’s Note:** Thank you to Joyce Johnson, MS, RN, Nurse Director, Brigham and Women’s Hospital, and Joan M. Vitello, PhD, RN, for their support of this work and commitment to patient care. Please address correspondence to Margaret Costello PhD, RN, Assistant Professor, Simmons School of Nursing and Health Sciences, 300 The Fenway, Boston, MA 02115, USA; e-mail: margaret.costello@simmons.edu.
Care were associated with lower odds of mortality and failure to rescue, greater patient satisfaction, and higher composite process of care scores for acute myocardial infarction, pneumonia, and surgical patients. These findings support the long-held belief that by the nature of their 24-hour around-the-clock close proximity, hospitalized patients are reliable reporters on quality of care (McHugh & Stimpfel, 2012). Nurses using keen analytical skills are in a prime position to report on behaviors that contribute to positive patient perceptions of their nursing care.

Study Design: Setting, Subjects, Instrument, and Ethical Considerations

This research was conducted on a medical surgical unit at a large urban academic medical center in Boston. Nurses were considered eligible for the study if they were cited by name in two or more Press Ganey® patient surveys of patient experience during hospitalization within the preceding year January 2014 to January 2015. The study was approved by the agency’s institutional review board. Ten nurses were identified by two or more patients as providing exceptional patient care. These nurses were personally invited by the researcher to participate in a focus group. Two focus groups were held on two different days, at the same time of day in the same room facilitated by the same researcher to accommodate nurses’ schedules. Nursing participation was voluntary, and all nurses agreed to participate in the study except one nurse who was out of town on vacation. The data collection and subsequence analysis were in line with classical grounded theory methods (Glaser, 1978). Open line-by-line coding analysis was initiated that led to the development of categories (Glaser, 1978). Written notes, or memos, added depth to the data analysis process (Glaser, 1978). From the examination of the categories and memos, a clear picture of a core category emerged. The coding process culminated with a relational model through which all substantive codes/categories are related to the core category (see Figure 1).

Results

The nine nurses included seven females and one male aged 34 to 62 years. There were four African American, four Caucasian, and one Vietnamese nurse. Three of the nurses had associate degrees, and six nurses had baccalaureate nursing degrees. Nursing experience ranged from 7 to 28 years. The experiences of the participants were unique and varied. Two major themes resonated with all the nurses: being present, and knowing the patient. The theme of knowing the patient had several subthemes that on first inspection could appear to be separate themes except for the insistence by the nurses that they needed to first know the patient before they could move forward with practices identified. The findings highlighted in this article are a summary of the major themes and related subthemes.
Knowing the Patient/Being Physically Present

An overwhelming theme was that of knowing the patient and being physically present. Nurses reported that knowing the patient was intrinsically linked to being physically present. It is from this relationship of knowing or understanding that nurses model their behaviors to best match their patients’ needs. Several subthemes emerged under the main theme: finding connections through commonalities, shared personal stories, the use of humor, and spiritual care.

The nurses agreed that being emotionally and physically present in the room with patients was of utmost importance in order to connect with and get to know them. They emphasized the importance of not just rushing in to complete tasks but really being present for patients.

There’s no way you can make those connections if you’re not in their rooms and I’m not saying pestering them, but to make some effort to connect with them as a human on some level is essential. So you can’t do that from outside the room. It’s impossible. You have to be at their bedside to some degree even if it’s just poking your head in, but chances are if you’re poking your head in and they’re happy to see you, they know that you really care about them and you’re checking on them.

I think that they can’t trust you if they can’t know you and sometimes they’re unable to do that because of how sick they are and you don’t want to be carrying on about yourself, but you want to be able to build that slowly so that they know that you think of them as a person.

You can’t make a connection if you’re not in the room with them. Presence is presence enough.

Finding Connections Through Commonalities

Nurses described how they asked patients open-ended questions to learn about their interests such as about hobbies, family, where they live. Nurses then reported that they made connections to their own lives.

I always look for a common thread to break that barrier: I find they often ask something back and I try to give them that without overtaking the conversation, but just to give a little bit and then that I think makes a difference because they’re so vulnerable. So if you can meet on a more even level that we both have lives other than you being sick then I think it disarms the situation a little bit.

It’s just understanding why they’re here, what their social issues are, what they’re anxious about, what touches them. I mean there are some guys in here who just want to talk about motorcycles. There are some guys here who want to talk about sports. There are some guys who want to talk about the stock market. They want to talk about world events. So you got to find out what that little niche is to communicate with them that way.

You’ve got to know your audience; I try to meet the patients where they are.

Shared Personal Health Experiences

Other nurses recalled how they shared personal health experiences that they felt their patients could benefit from.

I share my personal experiences with them about an ostomy and I can’t tell you how many are so grateful that I shared that. I was pregnant with it and can swim with it. I shared my experience. They’re like “wow.” Some even cry, like “Seriously, you live with an ostomy... you.” I’m like “yes me and I had a baby and I worked and nobody knows unless you tell them.

Now that I had the cancer I tell people just to let them know. It makes them feel like “I’m not the only one.”

Using Humor

The nurses described how they used humor when providing care. All were in agreement that knowing the patient was a key aspect of using this strategy as if the patient might not be receptive or the humor appropriate.

I think humor has a lot to do with it. I’m a big fan of humor and I like to use it whenever I can. I think it puts the patient at ease and I remember when I first started, everything was an emergency. Oh he needs Oxycodone and she needs to go to the bathroom and I think it showed and then I think patients can read you and so even if you’re down staff, having
a crazy day when you walk into their room it's just about them and you try to have your demeanor very calm. Humor, laughing, smiles.

I’ll do fun things with them, like real joke. I mean some people might even think it’s kind of silly but it makes them laugh.

I say there’s no expiration on your toe. Let me see, there’s no expiration date there. I say things like that to them, but after I know them, and they laugh.

Let them know that there’s a human connection. I think that makes a difference and then I like humor because I like to laugh myself.

**Caring for the Spiritual Needs of Patients**

Nurses in the group described the importance of caring for the spiritual needs of patients. All the nurses in the focus groups had provided spiritual care to patients, and most could describe times when they had prayed with or prayed for a patient. Nurses described praying with patients of faiths different than their own because they believed that this would make the patients feel better. Knowing the patient was an important aspect of knowing when and if a patient would be receptive to spiritual care.

I mean I prayed with people when they wanted to. For instance, I cared for a person who is Muslim. We both understood that we each have a different God and we didn’t name our God, but that doesn’t mean we couldn’t pray with each other. She held my hand and we said a prayer.

When people are sick, for the most part spiritually they don’t care what your beliefs are and their own, just that you’re a spiritual person, that you’re with them in probably one of their darkest moments, and you pray with them if they need to be prayed for or you just tell them I’ll pray for you. You got to feel out the right person for this.

**Discussion**

Nurses were informed that they had been selected to participate in the study because they had been identified by patients by name as contributing to positive patient experiences. Interestingly, nurses did not focus on the fact that they were experienced or expert nurses or technically savvy. All nurses focused their responses on the more compassionate aspects of the nursing role. This is noteworthy, as the open-ended nature of the questions was designed to elicit any number and focus of responses. However, the nurses in this study focused on the caring nature of their role. Previous researchers’ findings support that caring attitudes of nurses are associated with patient satisfaction (Palese et al., 2011).

The nurses in this study have an intuitive understanding of the need to understand the patient in order to connect in ways that can be helpful. For example, nurses were quick to point out those practices such as use of humor, prayer, or sharing personal stories with patients would never be used if the nurse did not think that the patient would appreciate and benefit from these interventions.

Researchers have indicated that patients use a variety of internal and external resources for dealing with their spiritual/religious needs during their hospitalization (Ellis, Thomlinson, Gemmill, & Harris, 2013). Nurses are in a key position to support the patients’ spiritual needs when hospitalized. However, researchers have reported that patients do not receive the spiritual care they desire while hospitalized due to perceived time constraints by nurses (Buswell, 2006; L. Pearce, 2009). When spiritual needs are not met, patients are at risk for depression and reduced sense of spiritual meaning and peace (M. Pearce, Coan, Herndon, Koenig, & Abernethy, 2012). The nurses in our study realized that spiritual needs are important to consider when providing patient care. They made an effort to get to know their patients in order to elicit patients’ spiritual care needs and their openness to using nursing spiritual interventions. They additionally reached beyond their comfort zone to provide spiritual support to patients whose religious practices were different from their own.

The nurses identified the use of humor as an important aspect of their interactions with patients. Researchers have indicated that patients appreciate humor as an important aspect of their health care experiences with health care staff. Humor has an effect on how patients cope at a time of challenge and crisis (McCready, & Payne, 2014). Even patients who are very ill recognize the benefit of humor. In a study of 100 palliative care patients, Ridley, Dance, and Pare (2014) found that a significant majority valued humor. The nurses in our
The study recognized the value of humor in a patient's course of care and actively sought out cues to determine if this was an intervention that would benefit the patient. Again as with each subcategory, the nurses provided the caveat that “knowing the patient” was a key factor in their decision of whether or not they planned to use humor in the delivery of their care.

Knowing the patient involves the nurse's cognition, perspective, awareness, experience, and reflection (Zolnierek, 2014). Through knowing the patient, the nurse develops an understanding of meaning for the patient. The nurses in our study held fast to their belief that physical presence was a key factor in knowing the patient. The nurses in our study made a conscious effort to be present for their patients; they keenly observed and inquired of their patients’ information to better inform their practice. They maintained an open connection with patients, by being present, monitoring for cues from the patients about what is important to them, such as the use of humor or providing spiritual care. Zolnierek (2014) found that nurses spending time with patients in order to acquire information and the continuity and consistency of contact also inform the nurses’ ability to know the patient. Being present with the patient was a major aspect of getting to know patients. As one nurse indicated, “You can't get to know a patient by sitting in a chair outside the room.” Nurses must communicate with their patients to uncover information that will help them provide meaningful care.

Conclusion

At the heart of the findings of our study is the concept of knowing the patient and being present. When asked why they thought they were identified by patients as nurses who provide exceptional nursing care, nurses reported being present and knowing the patient as major contributing factors. Patients identified the nurses in our study because they provide nursing care that involves connection and engagement with each patient. Connection and engagement are important aspects of being present and knowing the patient. Through presence and knowing the patient, the nurses in our study are able to promote patient-centered care that reflects not only expert, safe care but also care that is in line with the patients' needs and expectations.

References


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