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Older Adults' Perceptions of Feeling Safe in Urban and Rural Acute Care

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OBJECTIVE: The purposes of this study were to identify factors that influenced hospitalized older adults' perceptions of feeling safe and to identify differences in perceptions between rural and urban contexts.
BACKGROUND: Efforts are underway to ensure patient physical safety and improve care quality in acute-care environments. Perception of care is a unique and independent dimension of quality that includes patients' views of care and how these perceptions might affect responses to illness.
METHOD: Grounded theory method was used to identify the basic social process of feeling safe in acute care.
RESULTS: Older adults felt safe when nurses provided oversight, were predictable, provided personalized care, and were willing to advocate for them.
CONCLUSIONS: Findings are consistent with professional models that center on the human relational components of care. Nurse leaders can facilitate practice environments where relational aspects of nurse work, including patients' perceptions of feeling safe, are the norm, thereby creating exceptional patient care delivery systems.

Quality and safety have gained ongoing national attention since the landmark Institute of Medicine reports.[1,2] Nurse leaders have embraced change ensuring higher levels of patient safety and quality by maintaining continuums of care,[3] closing gaps between performance measures and expected outcomes,[4] designing nurse-friendly practice cultures,[5] creating environments where caring patient-nurse relationships thrive,[6] and translating evidence into practice.[7] Nurse-led organizations have made patient care quality and safety priority strategic goals and actively undertake initiatives to improve patient outcomes.[8] Furthermore, nurse leaders have been instrumental in the development and activation of partnerships necessary to minimize errors, thus keeping patients safe. Although much has been accomplished related to safety and quality and subsequent organizational transitions, less than optimal overall patient safety has been achieved.[9] A recent study of Medicare beneficiaries indicated that, during a 30-day period, 134 000 beneficiaries experienced at least 1 adverse event during hospitalization.[10]

A somewhat new approach to the evaluation of care relative to safety and quality is patients' perceptions of their hospital experience and how it affects their responses to illness. Patients' perceptions of care are now considered a unique and independent dimension of quality.[11] The experience of hospitalization in America can be a threatening experience, especially for older adults as they enter into the complex, stress-provoking, impersonal healthcare system. In addition to the impersonal character of the institution, noncaring healthcare providers can be indifferent during one of the most vulnerable times in patients' lives.[12] "Often, [patients] are left to wonder if they are safe and who will be there for them when they need it most."[6(p.IX)] These stressful experiences are accentuated by a persistent focus on disease, procedures, and treatments, rather than on the human experience of illness,

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hospitalization, and perceptions of feeling safe in a harsh environment.[13] Nurses are in a unique position to effect change in hospital experiences and, ultimately, desired outcomes for hospitalized older adults.

Four nurse-sensitive indicators of hospital safety and quality outcomes are particularly relevant to the hospital care of older adults. Three of the 4 indicators, hospital-acquired pressure ulcers, falls, and pain, are related to physical safety and can be empirically measured using existing scales. The 4th indicator, patients' experiences of care, refers to patients' perspectives of health providers' responsiveness to their specific needs and includes the manner in which care is provided.[11] A substantial body of literature has been published about physical safety; however, little is known about patients' experiences, an emotional component that includes the perception of feeling safe. Patients have reported that feeling safe during hospitalization has helped them relax, rest, and focus energy on recovery.[14-16] People who have experienced serious health events have described situations where feeling safe has contributed to their recovery.[16,17] More specifically, in a qualitative study, older adults provided insight about how feeling safe reduced their sense of risk.[13] There is little evidence that can be used to enhance or develop interventions used by practitioners related to feeling safe during hospitalization. The overall purpose of this study was to identify factors that created the perception of feeling safe for hospitalized older adults. Better understanding of feeling safe among hospitalized older adults can influence earlier recovery, a positive health outcome for the aging population.

Review of Literature

The number of older Americans is expected to double by 2030, growing to 72 million, which will represent nearly 20% of the entire population.[18] Older adults experience longer recovery time from illness and injury.[19] Compared with all other age groups, this is reflected in extended hospital stays averaging 5.6 days.[20] In addition, older adults utilize 43% of all acute-care patient beds in medical-surgical (MS) units.[20] These percentages will likely increase as the number of people 65 years or older doubles during the next 25 years. The anticipated increase in the number of people who turn 65 in the next 2 decades likely means an increase in the number of older adults for whom care will be provided by nurses in both urban and rural hospitals.

Differences exist between urban and rural healthcare institutions in the composition of clients and the expenditure of support for employees. Urban hospitals are located in large cities, and clientele is drawn from both the immediate surrounding areas and from the region. Because of the dense population and larger size, urban hospitals tend to have more educational, human, and financial resources. In contrast, rural community populations are low-density, nonmetropolitan settlements where access to services, including healthcare, is limited.[21,22-24] Rural areas have a higher proportion of persons 65 years or older compared with urban areas.[23] In comparison to nurses employed in urban hospitals who usually live in the immediate area, nurses in rural areas are logistically challenged for both employment locations and for educational opportunities. In addition, many rural hospital administrators focus on ensuring that there are physicians and hospitals to provide medical care to local clients rather than on nursing staff development and typically do not provide incentives to access resources for up-to-date practice and professional development.[22,24] The lack of attention to the development of healthcare professionals can compromise optimum delivery of quality patient care.[22,24] There is a stark absence of research focused on nursing care in rural hospitals compared with urban and suburban hospitals, a fact that underscores the importance of including all care contexts in research. Although there are differences in goals and resources in urban hospitals and rural hospitals,[23] there is relatively no evidence that supports the conjecture that differences in institutional goals translate to differences in nursing care.

Patients are admitted to acute-care hospitals because they need care provided by nurses, physicians, and other healthcare professionals.[25] Changes in patient care delivery systems over the last decade, including the complexities of an older, more vulnerable patient population and intensified nursing workloads, have resulted in less time spent in direct patient care by RNs.[26-28] Important nurse-patient interactions are sought by hospitalized older adults[13] and often get lost in the struggle to accomplish the work of tasks or treatments.[29] It is precisely through these interactions that nurse work is performed. Enhanced relationships are foundational for safe, quality health outcomes.[30] Emerging evidence suggests that hospitalized adults who encounter caring relationships with nurses report increased satisfaction,[31] increased comfort,[32] and an increased sense of security.[13,30] There is an emerging need for healthcare systems to be prepared to provide effective healthcare that is sensitive to the needs of older adults in both urban and rural acute-care hospitals.

The purpose of this study was to identify factors influencing feeling safe for hospitalized older adults. The aim was to extend and expand what is known about feeling safe for older adults in ICUs[13] to older

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adults who were hospitalized in acute-care MS units in urban and in rural hospitals. With this purpose in mind and preliminary research about the importance of feeling safe for ICU patients, the following primary research questions were proposed:

1. What factors influence feeling safe for older adults who are inpatients in an urban hospital?
2. What factors influence feeling safe for older adults who are inpatients in a rural hospital?
3. How are factors that influence feeling safe the same or different for older adult patients in urban and in rural hospitals?

Methods

A grounded theory method[33] was used in this longitudinal study of the social process of feeling safe for older adults in acute care. Qualitative research methods are used to explore understudied concepts and relationships. Specifically, grounded theory "produces knowledge of the social world,"[34(p538)] and this social process can be tapped by asking people about specific experiences and analyzing the concepts that are discussed during open discussion. Each concept was treated as a unit of analysis, and variation (dimension) was expected.[33] Philosophical assumptions relative to this research were that knowledge lies in the meaning that people attribute to their personal experiences, knowledge is closely tied to context, and knowledge is gained through people talking about their meaning.[35] Feeling safe has been linked to the nurse-patient interaction, which, during hospitalization, is an essential component of the social process.[13] Therefore, grounded theory method was used to identify the basic social process of feeling safe in acute care.

Sample

Purposive sampling[35,36] was initially used to recruit male and female adults 65 years or older from MS units at 1 urban and 1 rural non–Magnet®-designated hospitals for interview at discharge and again 2 weeks after discharge to explore their perceptions of feeling safe during hospitalization. Both hospitals in the study were located in 1 Midwestern state and reported census data as follows: bed count: urban = 143, rural = 101; hospital days: urban = 27 122, rural = 10 214. These older adults were unexpectedly admitted to an acute-care unit for 2 to 6 days. Sample size was evaluated as the study progressed and based on the degree of saturation of the emerging categories. Theoretical sampling[33] was used to target older adults whose experiences contributed specifically to the underdeveloped categories.[33(p203)] All participants were English speaking, could understand the purpose of the study, and were able to complete 15- to 60-minute interviews. The final sample size of 20 participants (rural n = 10, urban n = 10) (Table 1) was determined to be sufficient. All 20 participants were initially interviewed prior to discharge, and an appointment for a 2nd interview by telephone was made at that time. Three participants were lost to follow-up; 2 did not answer when telephoned, and 1 died. A total of 37 interviews were completed, transcribed verbatim, and analyzed. Data were collected from July 2011 to December 2011.

Data Collection and Management

A designated nurse who was employed by the hospital approached patients who met study inclusion criteria and determined if they were interested in hearing details of this study. After full explanation of the study details, interested patients consented and completed the 1st interview using a semistructured interview guide that was developed by the 1st author and constructed to elicit reflection upon hospital experiences. Questions such as "What does feeling safe in the hospital mean to you?" "What do nurses do that makes you feel safe?" and "Is feeling safe in the hospital important?" were asked of all participants; additional probes were used when further explanation of the experience was needed. Two interview sessions were conducted; the 1st was prior to hospital discharge, and the 2nd was 2 weeks after discharge to home.[37] Interviews were audio taped, transcribed verbatim, and organized using NVivo 8.[38] Institutional review board approval was gained through the university and through the hospital research council, and confidentiality was maintained throughout the study. Credibility was established through detailed

Table 1. Participant Demographics

Participants (n = 20)	Gender	Age (Mean, 75 y), y	Ethnicity, n
Rural n = 10	Female = 5	72, 75, 76, 81, 74	White = 10
	Male= 5	66, 66, 68, 69, 88	
Urban n = 10	Female = 7	65, 66, 69, 81, 85, 86, 87	African American = 1, White = 9
	Male = 3	67, 69, 90	

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description of data collection and analysis, thereby leaving a blueprint for carrying out similar research.

Data Analysis

A constant comparative technique[33] was undertaken beginning with the 1st interview and continued throughout the study to ensure that all concepts were explored and main categories were well developed. Recruitment and interviews were conducted until saturation was reached, meaning there were no new concepts discussed by participants.

Open Coding

Open coding was used to initially identify concepts that were used to construct the theoretical model of feeling safe in acute care (Figure 1). Interview transcripts were fractured into words, phrases, and sentences and were closely examined to determine what the participants were saying and how they were interpreting their experiences. Open coding[33] of words, phrases, sentences, and paragraphs was used to identify conceptual properties (characteristics that give a category meaning) and dimensions (range of variance). Seventeen concepts were identified and were compared dimensionally for similarities and differences in the properties.

Axial Coding

During axial coding, concepts were compared to identify differences and similarities leading to classification of concepts into subcategories (concepts that clarify and specify categories) and categories (repeated patterns of happenings). Concepts, categories, properties, and dimensions were identified and mapped. Concepts were then classified into 4 main categories, and individual categories were compared and contrasted with all other categories, treating each as the axis of the data complex and making clear the distinctions between main categories. Each of the 4 main categories were then integrated and further defined. The central category, feeling safe, captured the overall conceptualization of the research, and all other categories were related to it.[33] Relationships among categories were nested in structure (conditions in which the phenomenon is situated). Finally, refining major categories by selective coding and integration of categories were completed to form a substantive theory grounded in the data. Based on the emergent categories, a substantive theory was constructed (Figure 1).

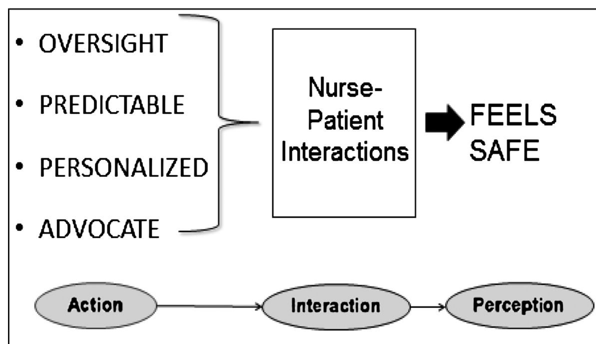

Figure 1. Theoretical model and social process.

Process

Process data were located and were examined for strategies used by participants in response to their hospital experience. The basic social process was grounded in the need for actual or potential interaction with a nurse, which was identified by participants as the basis for feeling safe in the hospital. Prominent concepts are discussed under the main category headings in the ensuing section.

Findings

According to appraisal theory, feelings are emotions that are experienced as a result of perceptions.[39] Feeling safe is an emotional state during which a person perceives that there is no imminent danger of injury or death. People distinguish between features of physical safety and emotional safety,[13,40] particularly when there is a perceived threat, such as having to unexpectedly be hospitalized and be treated for a short but severe episode of illness. The following are findings from interviews in which patients identified factors that contributed to their perception of feeling safe in acute care.

Oversight

Three concepts were grouped into the main category of oversight. Participants described their nurses as attentive, having the ability to anticipate care that might be needed, and frequently checking on them. About anticipation, 1 participant reported that she "just felt like they watch over the things that could happen." Having an attentive nursing staff was critical when 1 participant recalled having a hamburger for lunch, and he "started to choke and I hit the buzzer, and they were here before I put the phone down. Now that's an attentive nursing staff!" Older adults in this study appreciated the nurses checking both "during the night, even when I'm sleeping" and during the day when "you had to say your name and birthday every whipstitch, and that's a good idea!" The older adults in this study felt safe when nurses checked on them, were attentive, and could anticipate patient needs.

Predictable

Participants felt safe when the nurses were available and they could count on (trust) the nurses to be skilled, professional, competent, and responsive. They liked the predictability that when a nurse entered the room,

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the participants' well-being was of ultimate importance. One participant said, "I just trusted them. They were so proficient. I didn't have to worry," and another perceived that "she knew what to do and when to do it." Overall, 1 participant recalled that "they conduct themselves in a professional manner by knowing what they are doing," whereas another remembered that during catheter insertion "they were ever so professional, and they make you feel at ease. They help you."

Personalized

Nurses who interacted with the study participants on a personal level made them feel safe. They liked being treated like a unique person and appreciated a nurse who "knows my situation." Participants could sense the attitude of their nurses and if they "liked being a nurse" and respected and cared about their patients. One participant liked it when "they'd stop and talk to you and take the amount of time necessary." When asked about what nurses do that make patients feel safe, 1 participant reflected, "off hand, I don't know how to explain it… because you do feel safer with some than with others. So it has to be something about the demeanor."

Advocate

Participants felt safe when they could count on their nurse to intervene on their behalf. One participant recalled a situation during her hospitalization when one of her medications made her feel sick. She had a similar previous experience with a medication, and her doctor had her continue to take the medication, fully knowing it made her feel bad. This time, she recalled, "I told her (the nurse) that I wasn't going to take [the medication] anymore… and she said, 'okay, I will tell your doctor.'" She felt that the nurse was protecting her and acting on her behalf. Another participant felt supported and involved when nurses "explain to you what is being done and why" and "explained everything in detail."

Feeling Safe

Participants in both the urban and the rural acute-care units felt safe when their nurse provided oversight, was predictable, made their hospital experience personalized, and acted as an advocate. When asked if feeling safe in the hospital was important, all participants said "yes." One participant explained that if she did not feel safe "I wouldn't want to stay," and others said they would not want to return. Older adults in the study described a personal connection with their hospital because "it's your lifeline," and another summarized her hospital choice like this; "You go where you feel safe."

Older adults in this study spoke of enhanced outcomes when asked about why it is important to feel safe in the hospital. Thirteen of the 20 participants agreed that "it helps the healing process." Two participants reported feeling less stressed when they felt safe.

No older adults in this study reported feeling unsafe during their hospital stay, and there were no detectable differences between the perceptions of feeling safe for participants in urban versus rural acute-care units. In summary, older adults' perceptions of feeling safe during hospitalization were a positive for the patients and for the institution.

Study Rigor and Limitations

The process of data analysis was carefully followed, resulting in a theory that is grounded in data and exhibits sufficient specificity to be meaningful to practitioners.[33] The research process was carefully documented, and the audit trail that was kept during this study can be used in future replication studies, thereby lending credibility to the study and the resultant theory. Credibility and plausibility were supported by consulting colleagues with experience in qualitative data analysis who engaged in free and open dialogue about data and analysis.[41] Strength of this study was that 1 person conducted all interviews, which decrease interviewer variability and added to the reliability of the study.

This study was limited by convenience sampling, which, when compared with the metropolitan area, produced a somewhat homogenic and therefore nonrepresentative urban sample. Because most rural communities in the Midwest are ethnically white, the sample was more representative of the rural population. Older adults were recruited for this study, which limits the application to other age groups who would likely have different perspectives about feeling safe during acute-care hospitalization. In addition, this study focused on a specific population in a narrow context that created conditions for concepts directly related to experiences and processes to emerge. In this situation, the substantive theory that is grounded in the data cannot be generalized to a larger population but rather can be related back and used in like populations and contexts.[33]

Discussion

The theory of feeling safe developed from this study can be cautiously generalized to older adults who have experienced care in an acute-care hospital after a serious health event; however, the knowledge gained about conditions under which feeling safe operates for older adults in acute care will improve healthcare quality by informing nursing practice and thereby enhancing the efficiency and effectiveness of healthcare.

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The 4 factors associated with feeling safe reported by participants in this sample are processes of care that RNs do in the context of relationships with patients and families. Furthermore, they are consistent with caring-based professional practice models[6,42,43,44] that center on the human relational component of care. Although dissimilarities exist, no differences were noted between the participants' perceptions of feeling safe in the contexts of urban and rural acute-care units, indicating the need for nursing administrators to consistently attend to this aspect of care.

Conclusions

This study was foundational to a research program focused on the development and testing of nursing interventions that foster a hospital environment in which feeling safe for patients is the norm. Creation of a safe and caring environment may influence a reduction in recovery time and improve posthospital outcomes. Although the findings cannot be generalized, they do have important implications for nurse leaders. First, older adults in this sample viewed feeling safe important to their recovery and attainment of health outcomes. Second, when RNs provided adequate oversight, were predictable, personalized the hospital experience, and advocated for patients, the patients felt safe. These relational components of RN work must be upheld as a primary focus through appropriately balanced workflow and relationship-centered patient care delivery systems.[45] Nurse leaders can support this approach by facilitating work environments that allow nurses to practice this way and routinely assessing patients' perceptions of feeling safe.

In terms of research, results of this study will be used as preliminary evidence for the development of standardized, patient-focused, nursing interventions that support safety and quality in care delivery.[45,46] Evidence suggested a link between patients' perceptions of feeling safe and quality nursing care,[13] which might reduce length of stay and result in lower healthcare costs. In addition, results of this research provide further evidence for the American Organization of Nurse Executives' (AONE's) Transforming Care at the Bedside initiative focused on patient-centered care and are foundational to the AONE strategic plan[46] and guiding principles[45] for gaining knowledge useful for development of standardized, patient-focused, nursing care that supports safety and quality in care delivery to improve healthcare for all Americans.

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