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What really matters? A multi-view perspective of one patient's hospital experience

ABSTRACT

Background: 'Patient experience' is both recognised and solicited as a means of assessing healthcare delivery and a method for gauging patient centredness. Research comparing healthcare recipient and provider perceptions regarding the same episode of care is lacking. **Aim:** To identify what mattered to a patient and family member (healthcare recipients) during the patient's hospital experience and to examine the healthcare provider's awareness of what mattered. **Methods:** A qualitative descriptive investigation was undertaken using semi-structured interviews designed to compare multiple perceptions of one patient's hospital experience. Interviews were undertaken with the patient, family member, and healthcare providers. A definition of hospital experience was sought from each participant. Additional phrases as presented by the patient and family member were coded and grouped into categories and then salient themes. Phrases as presented by the healthcare providers were coded, and then allocated to the previously identified themes. **Findings:** One patient, his wife and seven healthcare providers (doctors (2), registered nurses (4) and a patient care orderly (1)) were interviewed. Definitions of 'hospital experience' differ between participants. Recipients include pre and post hospital admission periods, whereas providers limit hospital experience to admission. Three salient themes emerged from recipient data suggesting; medication management, physical comfort and emotional security are what mattered to the recipients. Awareness was dependent upon theme and differed between the providers. **Conclusion:** Hospital experience as a term is poorly defined, and definitions differ between recipients and providers of care. Healthcare providers are not always aware of what matters to the patient and family during their hospital admission.

Keywords: patient experience, patient centred care, patient satisfaction

BACKGROUND

Healthcare recipients are central to healthcare delivery, and as such quality care necessitates models that embrace the unique human being, thereby challenging biomedical models of the past (Balik, Zipperer, & Watson, 2011). At the forefront and gathering increasing attention amongst healthcare stakeholders is the model known as 'patient centred care' (PCC). While no globally accepted definition exists (Balik et al., 2011; Hobbs, 2009), PCC is respectful and responsive to the preferences, needs and values of the healthcare recipient (Australian Commission on Safety and Quality in Health Care (ACSQHC), 2011). In 2001 the Institute of Medicine's (IOM) landmark report *Crossing the Quality Chasm*, identified patient experience as a key aim of PCC. Current perspectives in healthcare agree that 'patient experience' is both

recognised and solicited as a means of assessing healthcare delivery and a method for gauging patient centeredness.

Benefits of improving experience range from increased satisfaction and reduced lengths of stay to improved outcomes and cost reductions (Cliff, 2012; Epstein, Fiscella, Lesser, & Stange, 2010; Wolf, Ekman, & Dellenborg, 2012). Patients also tend to choose hospitals based on experience (Abraham et al., 2011), and as such healthcare decision makers have been keen to adopt various strategies to measure experience (Australian Commission on Safety and Quality in Health Care (ACSQHC), 2011; Luxford, Safran, & Delbanco, 2011; National Health Service, 2013; The Beryl Institute, 2013; Zeis, 2012). The United Kingdom, United States, Canada, New Zealand and most European countries now gather patient experience or satisfaction data at some level (Centers for Medicare & Medicaid Services, 2013; Ministry of Health Manatu Hauora, 2013; Murray, 2008; National Health Institute for Health and Care Excellence (CARE), 2012; Pearse, 2005; Robert et al., 2011). The 2013 National Safety and Quality Health Service Standards (NSQHS Standards) now require all Australian accredited hospitals to survey for patient experience (Australian Council of Healthcare Standards, 2013; Pearse, 2005).

Healthcare institutions have turned to experts in PCC to facilitate the collection and analysis of experience data. The Picker Institute world leaders in PCC, developed eight dimensions of PCC (see Table 1) as a framework for defining the patient perspective and a means of measuring the patient experience.

Satisfaction surveys using the Picker dimensions are commonplace in healthcare, with many self-identifying as experience research (Boyd, 2007; Centers for Medicare & Medicaid Services, 2013; New South Wales (NSW) Government, 2013; Pearse, 2005). Experience refers to the process of care, and while linked, is different from satisfaction, which is a rating of experience (Bjertnaes, Sjetne, & Iversen, 2012; Browne, Roseman, Shaller, & Edgman-Levitan, 2010; Cawley, Waterman, Roberts, & Caress, 2011; Needham, 2012). Given this incorrect adoption of interchangeable definitions amongst the research, there is not an easily identifiable body of literature pertaining to patient experience.

Table 1 *Picker Dimensions of Care* (Source: Adapted from New South Wales Health and National Research Corporation Picker 2009)

Access to care	The extent to which an individual can obtain healthcare services.
Information and education	Access to and provision of truthful information and education designed to facilitate autonomy, self-care and promotion.
Coordination of care	Includes clinical care, support services and frontline patient care.
Physical comfort	Includes pain management, daily activities and living needs, surroundings and environment.
Emotional Support	Includes anxiety over physical status, treatment, prognosis, and impact of illness on the patient and others.
Family and Friends	Includes decision-making, caregiver support, and recognition of friend and family needs.
Respect for patient preferences	Includes involvement of the patient in medical decisions, providing the patient with dignity, and respecting autonomy.
Continuity and transition	Includes provision of information regarding ongoing requirements post discharge.

The recipient's perspective has long been considered a fundamental component of care delivery and evaluation (French, 2003; FrÖJd, Swenne, Rubertsson, Gunningberg, & Wadensten, 2011; Larrabee & Bolden, 2001; Marram, 1973). Perceptions of priorities and care delivery are influenced by time and outcome, and vary considerably between the recipients and providers of care (Boev, 2012; Cooke & Thackray, 2012; Lee & Yom, 2007; Leydon, Guerin, Eyles, Jacques, & Darlison, 2012; Suhonen et al., 2012). Despite this knowledge, there exists a clear gap in the literature regarding the real-time perceptions of the hospital experience from the viewpoint of the recipient (including friends and family) (Boev, 2012), and even less research comparing the recipient and provider perceptions regarding the same episode of care (Hanyok, Hellmann, Rand, & Ziegelstein, 2012; Small et al., 2007; Suhonen et al., 2012). Multi-

viewpoint experience research is imperative as McCance, McCormack and Dewing suggest ‘we might think we are delivering care that looks like one thing, but in reality it is quite another’ (2011, p. 1).

AIM

To explore the perceptions of one patient’s hospital experience, identifying what mattered to the patient and family (‘healthcare recipients’) and whether the healthcare providers were aware of what mattered.

METHOD

Design

A qualitative descriptive approach designed to elicit salient themes from semi-structured interviews was used. At the very core of qualitative research is the belief that no single reality exists and as such the goal here is not to find absolute ‘truth’ of the hospital experience, but rather to compare multiple realities as based upon various perceptions (Milne & Oberle, 2005, p. 413). This methodology is ideally suited to explore experience shared by individuals (Polit & Beck, 2008) and the perspectives of both recipients and providers of care (Chenail, 2011; Neergaard, Olesen, Andersen, & Sondergaard, 2009). The design also allows for flexibility of data collection and analysis (Brown, 2009).

Setting

This project was conducted at a 270-bed acute care private Catholic hospital located in a major metropolitan city in Australia. The hospital caters to a culturally diverse adult population.

Participant Sample and Accrual

Patients experience hospital processes and services first hand, thereby making their perspectives both unique and relevant (National Health Service, 2013). Experience however is by definition a unique involvement in or exposure to a certain event and as such a representative sample of a ‘patient’ is unobtainable. As such, we decided to conduct this study using one patient participant. The patient was selected based on ease of recruitment. Potential patient participants were suggested by the hospital’s head of neurophysiology and were recruited and consented during admission. The first patient willing and able to participate and who met the

inclusion criteria, was selected. Non-patient participants, including a family member were identified by the patient as key people impacting his hospital experience and were consented by personal correspondence.

Inclusion Criteria

- English-speaking adult.
- Willing/ able to participate.
- Patient participant: Hospital inpatient. Planned length of stay greater than 72 hours.
- Non-patient participants: direct patient contact during admission.

Data Collection

Semi structured face-to-face interviews were conducted using a stimulus guide questionnaire informed by the Picker dimensions. Patient and family member interviews were conducted individually post procedure, together immediately post discharge and then together three weeks post discharge prior to the patient's follow-up appointment.

Perceptions of experience change over time and are impacted by outcomes (Bjertnaes et al., 2012; Cawley et al., 2011; Shattel, Hogan, & Thomas, 2005; Small et al., 2007). In order to minimise recall inaccuracies and bias, and to manage potential implications regarding healthcare recipient and provider power imbalances, interviews with providers were conducted within two weeks post patient discharge (Black, 2009; Manary, Boulding, Staelin, & Glickman, 2013).

The patient interview took place in the patient's hospital room. The first patient and wife interview took place in their hotel room and all other interviews were conducted in an interview room within the hospital campus. A semi structured interview technique was used allowing for qualities of experience to surface (Clarke, 2006). Prompts were used to elicit more information or to clarify – 'tell me more about...'. All participants were invited to discuss their perceptions of 'hospital experience' as a definition ('what does the term hospital experience mean to *you*?'). The patient was asked to discuss his hospital experience. The others were asked to discuss their perceptions of the patient's hospital experience. Care was taken to create an open and trusting interview environment (privacy and comfort were respected, open ended questions were asked where possible).

Interviews ranged in length from fifteen to sixty minutes, all conducted by the principal interviewer who is also a healthcare clinician. The audio-recorded interviews were transcribed verbatim, and transcripts checked against the recordings. Identifying information was removed and participants assigned a pseudonym. A hard copy and digital copy of the data were kept securely within the hospital campus.

Data Analysis

Using the aim as a guide, recurrent words and phrases throughout the data were coded. A saliency analysis was used, whereby recurrence of codes and or importance determined the resulting themes (Buetow, 2010). Phrases as presented by the healthcare providers were similarly coded, and then allocated to the previously identified themes. Unlike traditional data analysis, themes were created based on frequency, saliency and nature of responses by the patient and family member only, as the recipient's experience was the primary unit of analysis.

Rigour

Transcripts were coded independently by two researchers, then together to compare coding and salient themes. A third independent researcher was available to mediate any coding disparities or disagreement, however this was not required.

Ethics

Ethics approval was obtained from the Tasmanian Health and Medical Human Research Ethics Committee (HREC) and the St Vincent's Private Hospital Sydney Practice Development and Research Council (PDRC).

FINDINGS

Ten participants were recruited for this study: 2 healthcare recipients (1 patient and 1 family member (wife)) and, 7 healthcare providers (4 Registered Nurses, 2 Doctors and 1 Patient Care Orderly). Data saturation occurred after three interviews with the healthcare recipients, with the final interview not contributing any further categories.

Characteristics

Table 2 *Participant details (n=9)*

Participant	Gender	Position	Department
Patient	Male		
Wife	Female		
Doctor 1	Male	Head of Neurophysiology	Neurology
Doctor 2	Male	Consultant Neurologist	Neurology
Nurse 1	Female	Registered Nurse & Clinical Nurse Educator	Neurology Ward
Nurse 2	Female	Registered Nurse	Intensive Care
Nurse 3	Male	Registered Nurse	Intensive Care
Nurse 4	Female	Registered Nurse	Neurology Ward
Orderly	Male	Patient Care Orderly	Intensive Care

The patient selected was a 49-year-old male with Parkinson's syndrome, a progressively degenerative neurological disorder. The reason for hospital admission was a planned Deep Brain Stimulation (DBS) insertion (during an awake craniotomy), designed to alleviate the disabling movement symptoms associated with Parkinson's syndrome. Length of hospital stay was eight days.

Three themes of what mattered most to the patient and wife emerged from the recipient data including:

- a. Medication Management**
- b. Physical Comfort**
- c. Emotional Security**

The Healthcare Providers' interviews were then coded to these themes. Perceptions of 'hospital experience' as a definition differed between participants in terms of timeframe. All participants had a similar opinion regarding the recipient's overall hospital experience. Awareness of what mattered to the recipients was theme dependant and differed between the providers. Expectation, outcome and time were identified as modifying the perception of the hospital experience for the recipients. People and communication, were identified by all participants as determinants of a positive or negative hospital experience.

Hospital Experience

The term 'hospital experience' for the patient changed over the three interviews. His initial response when asked 'what does the term hospital experience mean to you?' was a rating of the doctors providing care, 'Dr 1 has been very good. He made me feel at ease from day dot. And Dr [local neurologist] is a good bloke'. The patient's second statement was more broad and related to a sequence of events which suggests his hospital experience started at the first meeting with Doctor 1, several months prior to admission 'When I walked through the front doors...the original interview. The follow-up tests, the operation and that...' For the patient's wife the 'hospital experience' also commenced long before admission;

I should go back to the start...He started shuffling...I was beginning to think he had had a stroke...I needed to know the logistics of what I had to organise – knowing times and dates...accommodation things like that (Wife).

During the third interview the patient stated the hospital experience is 'what we went through' with both stating the 'hospital experience' was not limited to the period of hospital admission. This timeframe differs significantly from the definitions proposed by the providers (with the exception of Nurse 1 who referenced 'a smooth transition between entering and leaving'). No provider participant made reference to any pre or post admission period as a component of the hospital experience.

When asked to define 'hospital experience' providers gave definitions of what they believed made for a 'good' experience; 'The caring attitude...the communication with the patient' (Nurse 3), and 'Being treated with dignity and respect' (Nurse 1). Provider definitions also listed components of care; 'Physical structure, cleanliness, courteousness, and attentiveness of staff' (Doctor 1), 'Nursing staff, the doctors and their skills, their attitude...the environment...the building...the food' (Nurse 3) and 'The care they receive, the information, how they have been treated as a person' (Nurse 2). Hospital experience was also defined by the providers as a personal understanding as perceived by the patient 'How the patient viewed their time while they were in hospital' (Doctor 2), 'Whether he feels he is getting better or not improving...How the patient experiences their stay' (Doctor 1).

Personal interaction as a component of experience was highlighted by the patient; 'I have had good experiences all round. The people in the hospital have been good' and by the providers; 'I think it is interaction between all the staff members...that can just change their whole

experience completely' (Orderly). One provider highlighted the importance of people by defining the hospital experience as simply 'the people he comes across' (Nurse 4).

Overall Experience

The recipients were pleased with the overall experience and personal interaction seems to have been the main reason, 'I have had good experiences all round. And the people in the hospital have been good' (Patient), 'Honestly we have been very happy' (Wife), with both agreeing the successful outcome has influenced their perceptions of the experience; 'Yeh, cause its successful yes it' (Patient). Expectations also modified experience 'It is a hospital after all. It's not a five star restaurant' (Patient).

All providers stated the patient had a positive overall experience, however the depth of their conviction varied as did their rationale. Statements ranged from 'He was thrilled...[with] the post-operative management and the staff' (Doctor 2), 'He felt good in his Parkinson's and in his body...he was happy. He thought very highly of the staff' (Doctor 1) to 'I don't know what he actually felt like...I assumed as far as I can say ICU is pleasant – he maybe had a pleasant stay?' (Nurse 2).

What Mattered

When asked directly what mattered most during the hospital experience the patient identified the 'operation', 'people', 'family' and

The doctors...when I saw [Doctor 1], and even [Surgeon]...I probably would have still went ahead with it in the end but it wouldn't have been sort of as positive (Patient).

When his wife was asked what mattered most, she replied, 'that the operation happened.' Both Doctors identified that the surgery and outcome were what mattered most to the patient, 'The fact the surgery could be performed on him...and not be associated with any complications' (Doctor 2) and 'to feel that the operation had gone well' (Doctor 1). Relief of anxiety and personal interaction was the most common response from all providers. 'He was quite frightened, it was important to know that every hour we were going to make sure everything was alright' (Nurse 2), 'When the patient is admitted to ICU they are always worried...you say "OK you are safe"' (Nurse 3). Only one provider (Nurse 1) articulated 'family' as what mattered most during the hospital experience.

Theme 1: Medication Management

Medication management was not highlighted by the recipients as what mattered most when directly questioned, however medication timing and administration were repeatedly mentioned over the three interviews as having impacted their hospital experience. Late medications were the main concern for the patient. ‘Sometimes the medication might be a couple of minutes either side, but I’m fairly anal about that. I like my medication when it’s on time’. Timing was also important for his wife:

He likes his meds on time. He stood at the door...It annoys him...But he wouldn’t say it to your face... He would stand there looking out that door.
(Wife).

Only one provider mentioned timing as an issue ‘He might have been unhappy when I dropped his medication – [I said] “I’m sorry I have to do it all over again”’ (Nurse 2). When specifically prompted – ‘Were there any issues with medications?’ awareness varied amongst the providers with responses ranging from ‘I think he was very pleased and as far as I am aware there were no issues with that’ (Nurse 1) to

I might have been a little bit late to give medications...because you know with the lap over time...when we come on at one thirty medications are due (Nurse 4).

Assumptions and expectation clearly shaped the experience for the patient and wife;

I knew they were busy. Well they have got a job to...I don’t begrudge them doing their job. There was someone there in more pain than I’m in (Patient).

All patient comments regarding medication timing were accompanied with statements of ‘others being more important’, yet when asked to assume he was equally important, the patient replied ‘Well they wouldn’t have forgotten about me then would they?’ Both recipients expressed difficulties understanding why medications were late when the ward did not appear busy; ‘We both noticed it was really quiet in here and he still wasn’t getting his meds on time... (Wife), ‘It didn’t make sense why?’ (Patient).

Handing over medications to the hospital staff to administer also impacted experience for the recipients, yet this was seen as inevitable;

I just accepted they had to take it off us. You can’t have people in there taking their own medication when they want can you? I probably would have liked to look after my own medications, cause I’m used to that (Patient).

The wife confirmed the importance of looking after his own medications ‘...he maintains his own medication [at home] and I think that’s good for him...it was hard for him to give up the meds’. There was no obvious awareness of this difficulty amongst the providers and when directly questioned their perceptions did not match the recipients. ‘He was actually happy for us to do it, I sort of discussed that with him...and he said “yeah no problem”’ (nurse 1). When asked about self-medication Doctor 1 stated that assuming the medications were left unchanged post-surgery the patient ‘...could have conceivably self-medicated’. When asked ‘who decides if the patient can self-medicate?’ no-one stated the patient or wife would be part of the decision-making process ‘It is up to the doctor and usually the staff and myself’ (Nurse 1) and ‘I would decide that with the nursing staff’ (Doctor 1).

Theme 2: Physical Comfort

Impacts of physical comfort expressed by the recipients related to food, sleep and pain. The patient stated he often felt hungry during admission, with his wife reporting that his constant movement due to Parkinson’s meant he required more food; ‘It was a good size meal for me but maybe not for a man, because he uses all that energy with the movement’ (Wife). Only one provider suggested food might have been an issue, although not necessarily for this patient: ‘Food is always a general problem’ (Nurse 1).

The bed was also a concern for the patient: ‘[It] was woeful...no support. I just couldn’t sleep properly...I was waking up every two and a half hours.’ While the bed was not the first issue mentioned during the original interviews, when asked at the final interview ‘Have you thought about anything else since we last talked?’ the patient’s first response was ‘the bed was still shit’. Again the patient mentioned his expectation impacting experience: ‘But that’s just a hospital bed in the end isn’t it?’

The resulting lack of sleep rather than the discomfort of the bed was of more concern for his wife: ‘That is a fairly big thing, if you can’t sleep or you can’t relax’ (wife) however the patient stated ‘I didn’t come here to sleep; I came here for the operation’. No provider mentioned the bed or sleeping as an issue for the patient, however his bed was changed during his stay.

Pain was an issue for the patient in intensive care ‘I was in a fair bit of pain...I knew I’d be in pain, but I just underestimated the pain a fraction’. His wife stated Doctor 1 informed them, however they both expected it would be less severe. ‘Doctor 1 said we’ve got pretty good drugs.

That was about as quick as the conversation was. There was no – “oh you’re gonna be really sore”” (Wife). Doctor 1 reported an awareness the patient was in pain post-surgery ‘He was complaining of pain over the tunnelling site’ (Doctor 1), although Nurse 2 who cared for the patient in Intensive Care stated ‘his pain was controlled and he was comfortable all night’.

Theme 3: Emotional Security

Feeling safe and secure was highlighted throughout the recipient data as an important aspect of their experience. People and communication appear to have been the catalyst for a positive or negative experience regarding the recipient’s emotional security. Both recipients expressed the importance of truth and trust;

I think he was happy [Doctor 1] had told him personally what was going on and not just fobbed him off...he has been comfortable from day one with [Doctor 1] and that’s huge...because if he is happy, I have got to be happy (Wife).

For the patient trust was based on expectation and assumption ‘I come in here with a theory. I trust Doctor [local neurologist] and if he trusts him [Doctor 1] – I trust him’.

All providers discussed truthful communication as impacting the recipients’ experience: ‘I was open and honest...I explained at the beginning of the night that’s what going to happen’ (Nurse 2). ‘I warned them...my [father] was very ill...there is a good chance that I will have to go...they were very understanding (Doctor 1).

‘Truth’ as a modifier of experience was again not necessarily patient specific;

I just make sure that they know exactly what is going to happen before it happens...if you get the trust in someone they are not going to tense up (Patient Care Orderly).

Sharing a personal connection also appears to have impacted emotional security;

[Doctor 1] explained what he had to do and I said family comes first...I lost my own [relative]... so I understood. [Doctor 1] apologised profusely. I said no worries at all Doc. You do what you’ve got to do (Patient).

The patient's wife stated;

I think [Nurse 1] has probably impacted on me more than anything...she said I have personal knowledge, I understand. And I have had people say to me oh I know what you are going through but they don't. They don't know (Wife).

Nurse 1 identified the importance of shared experience regarding the wife's experience 'If you relate in some way – people instantly relate to you and you have that instant connection'.

Feeling cared-for was identified by the recipients as having positively impacted their experience with physical presence an indicator of caring for the patient. 'The doctors cared too...[Surgeon] has been in every day, Doctor 2 has been in a couple of times...they have all been good'. Perceived caring behaviours were also important to the wife, however she identified knowledge of patient specific details as proof of caring:

[Nurse 1] was actually watching him...and she said later in the day ... "you haven't got that swagger about you", so they might not be talking to him or beside him but they are taking notice (Wife).

One provider highlighted the importance of personal interaction in feeling cared for: 'I think they do feel like they are cared for because they come back and they see familiar faces' (Nurse 1).

Anxiety was mentioned several times throughout the interviews. For the patient, who admits he is normally an anxious person, people were responsible for alleviation of fear:

[Doctor 1] put me at ease...he just sort of had that way with him...he got down and talked to you. I was nervous. But I went in there looking on the bright side (Patient).

For his wife the patient 'felt comfortable with the doctors so [she] wasn't worried'. Anxiety peaked prior to and during the operation for the wife and here communication impacted the experience;

I sat in the room for a little while...the nurse said "are you OK?", and I said "I'm a bit I just didn't know whether to leave or come or go"...he just sort of calmed me down (Wife).

The anxiety peaked during surgery due to expectation and communication issues;

They said the surgery could take up to seven hours...I heard them say it but I didn't take it in...three o'clock came...I started thinking right it's not going to plan...(Wife).

For the providers, relieving the patient's anxiety was identified as important and all articulated communication was key:

When people are off med, not only are they off in their body but they are off their soul...they often feel apprehensive, vulnerable...we try and create an atmosphere of quiet calm...telling the patient what is happening at any given point so there are no funny surprises (Doctor 1),

It wasn't information overload. I am really good at judging how much to tell people...based on what they give me in terms of feedback (Nurse 1),

He was quite frightened so it was important to know that every hour we were going to make sure everything was alright and that was someone always there... We had very good communication (Nurse 2).

DISCUSSION

This study has explored perceptions of the recipients' hospital experience and the extent to which healthcare providers were aware of what mattered to the recipients. Hospital experience as a definition has different meanings for recipients and providers of healthcare and those providing care do not always exhibit awareness of what matters to the recipients. The operation and people were identified by the recipients as what mattered most, however medication management, physical comfort and emotional security were what they discussed at length. Levels of awareness of these issues varied amongst the healthcare providers. Expectations, outcome and time influenced the recipients' perceptions of their experience. People and communication were identified as the key modifiers determining a positive or negative experience.

Hospital Experience

This study confirms the view that patient experience data provides unique insights into specific episodes of care, yet as a term 'experience' remains poorly defined (Balik et al., 2011; Bjertnaes et al., 2012; Hobbs, 2009). Hospital experience for the recipients includes an extended pre- and post-admission period, which differs significantly from providers who see the hospital experience beginning and ending with admission and discharge. This extended period of experience has recently been identified by researchers outside the health industry, who have found the 'airport' experience extends far before and beyond time spent at an airport (Fattah, Lock, Buller, & Kirby, 2009). Picker Institute definitions of patient experience do incorporate extended timeframes in their 'patient experience' definitions by including 'access to care' and

‘continuity and transition’ (Picker Institute, 2013). Such domains however are often overlooked by providers with a vested interest in the ‘hospital experience’ only, as one or both of these domains are often excluded from hospital experience research (Angela Coulter & Cleary, 2001; A Coulter, Fitzpatrick, & Cornwall, 2009; Jenkinson, Coulter, Bruster, Richards, & Chandola, 2002; Jha, Orav, Zheng, & Epstein, 2008). The Cleveland Clinic, reputed for medical excellence and valuing patient experience, has coined the phrase ‘managing the 360’ (Merlino & Raman, 2013, p. 113), a definition which sounds all-encompassing and therefore promising, yet by their own admission refers to a period which ends upon discharge (Merlino & Raman, 2013, p. 113). While a clear and mutually agreed-upon definition remains elusive, there does however appear to be agreement between providers and recipients that people are the key modifiers of the ‘hospital experience’. This view supports ‘patient experience’ definitions whereby ‘interpersonal aspects of care’ are addressed (Ministry of Health Manatu Hauora, 2013, p. 9).

Overall Experience

Experience measures are often discussed in terms of satisfaction ratings, and to that end the providers and recipients were aligned in their rating of the overall experience. Experience however refers to the process of care (Ministry of Health Manatu Hauora, 2013) and using satisfaction scales, or even attributing meaning to participant comments such as ‘good’, or ‘positive’ is potentially misleading (Bjertnaes et al., 2012; Cawley et al., 2011). This study confirms the view that patients can be satisfied with care, yet the care provided is not necessarily optimal (Sørli, Torjuul, Ross, & Kihlgren, 2006). A consensus of opinion regarding overall satisfaction may also suggest patient-centred practice, however such an accord is arguably only of value if there is an agreement as to why the recipients are satisfied, which is not always the case.

Expectation (such as not expecting ‘five star’ service) and outcome (operation success) influenced the recipients overall view of their experience, or at least their satisfaction with the experience. This is neither new nor surprising given that perception of experience is shaped by values and worldviews that are formed well before any hospital admission and similar findings have been well documented (Bjertnaes et al., 2012; Cawley et al., 2011; Jennings, Heiner, Loan, Hemman, & Swanson, 2005; Shattel et al., 2005; Small et al., 2007). While expectations may account for different perceptions of similar experiences (Bjertnaes et al., 2012), it is the meeting of expectations that appears to impact satisfaction (Bowling A, Rowe

G, & McKee M, 2013). The patient's assumption that the service would not be 'five star' was in fact a negative expectation met, which ironically results in an acceptable level of satisfaction. Again this highlights the limitation of satisfaction ratings.

What Mattered

What the recipients stated mattered most (the operation and people) differed to what they discussed throughout the interviews (medication management, physical comfort and emotional security). While 'people' did figure prominently amongst their data, the patient himself never mentioned the actual operation. This is of particular interest given the patient was uniquely able to comment on the experience as it was an awake craniotomy. Negative or unexpected events often result in narration and re-storying as a means of making sense of an experience (Moore, 2012). One could speculate the successful outcome influenced the patient's need to mention the operation or potentially explains why other issues were discussed instead. This disparity at the very least confirms the importance of multimodal methodologies in obtaining patient experience data (Australian Commission on Safety and Quality in Health Care (ACSQHC), 2011). The doctors in the study identified the operation as being what mattered most to the recipients, suggesting either a degree of insight or alternatively an assumption that the operation is always what matters most. All providers identified people as key modifiers of experience, suggesting again insight or simply that healthcare is always regarded as a humanitarian industry.

Theme 1: Medication Management

Medication management issues as framed in the Picker dimensions are typically considered issues of coordination of care (Picker Institute, 2013). Timing errors and coordination issues are well documented as modifiers of experience (Carney Anderson & Fagerlurd, 2013; Lee & Yom, 2007). This study supports the view that medication timing is a determinant of experience, and that imperfect-timing is often due to problems with care coordination (Gesell & Wolosin, 2004). This study also concurs that patient characteristics (such as a diagnosis of Parkinson's Syndrome) impact experience (Holzer & Minder, 2011). Individual needs and wants necessitated close attention to medication timing. Timing therefore also falls under the Picker dimension of respect for patient preferences. Such an adherence to healthcare provider routines rather than receiving care based on needs and preferences is not uncommon (Akin & Erdogan, 2007; Institute of Medicine (IOM), 2001; Kirana, Rosen, & Hatzichristou, 2009).

Medication management in this case also appears to be an issue of information and education. The patient did not know about the possibility of self-medicating. While his preference was to self-medicate, his apparent satisfaction that he couldn't was based upon a lack of information. The literature on patient experience suggests that a lack of knowledge impacts experience (Carney Anderson & Fagerlurd, 2013; Davis, Vincent, Henley, & McGregor, 2013; Dougherty, 2010; Skär & Söderberg, 2012). In order for patients to play an active role in their healthcare experience, they must have the necessary information (Davis et al., 2013) and accordingly information access is a prerequisite to patient-centred care (Australian Commission on Safety and Quality in Health Care (ACSQHC), 2011). The patient's wife knew how the patient felt about his medications and yet she had no input. Respecting and soliciting unique family input comes under the Picker dimension of 'family and friends', again suggesting medication management is not limited to one Picker dimension. Perhaps the most concerning issue in terms of PCC is the fact neither patient nor wife were identified as participants to be included in potential decision-making discussions regarding medication management.

Theme 2: Physical Comfort

Physical comfort was a concern for this patient and is its own separate Picker domain. Comfort as a general priority ranges from high (Green, Forster, Young, Small, & Spink, 2008; Small et al., 2007) to low (Reeves & Bruster, 2009). Cleanliness and noise are often cited as experience modifiers, however these were not mentioned in this study (Carney Anderson & Fagerlurd, 2013; Davis et al., 2013; Shattel et al., 2005; Wilson & Barton, 2012), suggesting again the subjective and idiosyncratic nature of experience. Food as an issue is a common theme in the patient experience literature (Green et al., 2008; Reeves & Bruster, 2009; Small et al., 2007). In this case food is not only an issue of physical comfort but also need-specific, which falls under the Picker domain of respect for patient preferences.

The impact of pain on experience is well documented (Aslan, Badir, Arli, & Cakmakci, 2009; Dunham, Ingleton, Ryan, & Gott, 2013; Schoenwald & Clark, 2006). This study confirms the view that a disconnect often exists between perceptions of pain by the patient and provider (Sanderson, Morris, Calnan, Richards, & Hewlett, 2010). The experience of pain also pertains to information and education (knowing what to expect) and a lack of involvement of family and friends who in this case knew the patient was uncomfortable, but said nothing. Interestingly physical comfort appeared more prominently in the patient's discussions once he had been discharged, which supports the view that physical comfort and pain relief are associated with

a high recall bias (Wong, Coulter, Cheung, & Yam, 2013). Alternatively, increases in time between an episode of care and survey, result in poorer patient experience scores overall suggesting perceptions of experience change negatively over time (Bjertnaes et al., 2012). There was very little insight among providers that physical comfort was an issue for this patient, confirming again the concept that awareness of an individual's wants and needs are not often met (Akin & Erdogan, 2007; Gesell & Wolosin, 2004; Suhonen et al., 2012).

Theme 3: Emotional Security

While emotional security is typically addressed under the Picker Domain of 'emotional support', again this study has found that aspects of care are multidimensional and cross Picker dimensions. Emotional security is also an issue of information and education, respect for patient preferences and friends and family.

Truthful communication impacts the recipients' sense of emotional security. While communication falls under the Picker domain of information and education, problems with truthful communication often stem from a lack of respect for autonomy that suggests the respect for patient preferences Picker domain (Nørgaard, Kofoed Poul, Ohm Kyvik, & Ammentorp, 2012). Sharing a personal connection equally impacts the hospital experience for the recipient, which in turn lends to a relationship that is both enduring and profitable for the healthcare organisation (Robinson, 2010). While care processes, at least regarding medication management, continue to appear routinised, meaningful relationships between the recipients and providers can be formed which is in contrast to the literature suggesting routines act as a deterrent to this process (McCormack, Karlsson, Dewing, & Lerdal, 2010; Wolf et al., 2012). Establishing a personal connection with the doctor in particular appears to impact the patient's emotional wellbeing, however this could be due to the existence of a unique 'awake craniotomy' patient-to-neurosurgeon relationship (Fletcher, 2012).

Feeling cared-for is linked to physical presence for the patient, which is in line with previous studies suggesting that having nurses nearby is beneficial to the patient's experience (Shattel et al., 2005). Human-to-human contact also increases the feeling of security for patients (Shattel et al., 2005), although simply knowing staff are 'watching' and therefore 'caring' may be sufficient. Only one nurse articulated the importance of feeling cared-for, although it was attributed to familiarity rather than presence. This study confirms the position that perceptions

of care, experience and priorities differ between providers and recipients of care (Cooke & Thackray, 2012; Lee & Yom, 2007; Suhonen et al., 2012).

Relief of anxiety is important to the recipients and impacts experience (Wassenaar, Schouten, & Schoonhoven). Once again, people and communication are modifiers of the experience. While issues of anxiety traditionally fall under the Picker dimension of emotional support, familiar human contact increases a sense of security, (Shattel et al., 2005) and as such the involvement of friends and family (a Picker dimension) is linked to the experience (Balik et al., 2011). Communication (Picker dimension ‘information and education’) was both the cause and cure for anxiety. For the wife a lack of communication and understanding led to unnecessary anxiety during the procedure, whereas timely, truthful and appropriate communication resulted in relief of anxiety for the patient. There was an awareness of anxiety being mitigated by a sense of connectedness (suggesting a level of respect for patient preferences) amongst the providers, which is consistent with previous findings (Shattel et al., 2005). Taking the time to build relationships reduces anxiety and this is both understood by providers and appreciated by the recipients (Egestad, 2013).

Limitations

Experience is by nature an individually perceived phenomenon, however single cases are not able to advance generalisations on a research topic. A patient’s perception of his or her hospital experience is dependent upon a potentially unlimited set of constructs (Elliott et al., 2009; Jha et al., 2008), and as such, larger sample sizes are not necessarily of more value in considering what matters to the patient or family. Further research is however recommended to replicate and expand the number of study participants to determine whether healthcare recipients are aware of what matters to their patients in various settings and populations. Asking recipients about their experience arguably changes the experience, although no alternative exists. Similarly, asking the providers of care what mattered to the recipients does not mean they necessarily gave thought to it or acted upon it during the episode of care, and therefore the passage of time is a limitation. This study is also limited in that the providers’ level of experience, time spent with the patient nor the organisational culture was considered. These may significantly impact the ability and desire of healthcare providers to identify what matters to the patient.

Significance for the Community

Qualitative descriptive is a useful methodology to explore what matters to healthcare recipients during the hospital experience, and to ascertain the extent to which providers are aware of what matters. While interviews are time consuming they often provide more information than a questionnaire (National Health Service, 2013) and as this study suggests responses to single questions differ from non-restricted free flowing narrative. Therefore the use of qualitative descriptive methodology and multimodal hospital experience data collection tools is recommended.

The differences in value attributed to issues during the healthcare experience suggests a need for real-time experience data collection, a view echoed in previous studies (Macdonald, Wilson, & Konus, 2012). If healthcare providers and administrators are able to identify issues in real-time there is not only the potential to address the issue immediately, but there also may exist a synergistic opportunity to capitalise on what the hospitality industry terms – the ‘service recovery paradox’. This paradox suggests that addressing an actual problem can lead to a higher level of satisfaction – or potentially a better experience than if the problem had not occurred (Mount, 2012). Further research into this area is warranted.

There is a danger in focusing on specific moments of the patient’s experience as it diverts attention from the ‘end-to-end journey’ (Rawson, Duncan, & Jones, 2013, p. 90). While the Picker domains are a useful set of criteria for assessing patient centred care and experience it is recommended that the domains are not considered in isolation when forming patient research questions nor when analysing findings, as the hospital experience is multidimensional and focus on one domain should not be at the expense of another.

This study is not concerned with finding the truth of the experience, and as such little weight should be attributed to the individual findings (for example while the bed may have been an issue for this patient it may not have been an issue for any other patient in the hospital). The significance of this study lies in the differing perceptions of one patient’s experience, and the identification (or lack thereof) of what mattered to the recipients. This case is specific, however the situation is not. Given the desire and/or obligation to practice PCC, healthcare providers must have an understanding of what matters to recipients during their hospital experience. Further research should focus on:

1. Obtaining a mutually agreed upon definition of ‘hospital experience’

2. Creating and measuring interventions designed to obtain and react to real-time experience data.
3. Identifying possible common modifiers of the 'hospital experience'.

CONCLUSION

This is the first study to explore the healthcare provider and recipient perceptions of the recipient's hospital experience regarding the same episode of care. This study has found hospital experience data is valuable as a means of assessing the quality of PCC, yet to-date the term 'hospital experience' remains poorly defined. Healthcare providers are not always aware of what matters to the recipients during the hospital experience. All providers had knowledge of the importance of the emotional wellbeing yet few were aware that physical comfort and medication management were an issue. Expectations, outcome and the passage of time influence the recipient's perceptions of their hospital experience. Both recipients and providers agree that people and communication are the catalysts for a positive or negative experience.

The Picker Dimensions of experience are widely used as a tool for gathering experience data and as a framework for analysing results. It would appear however that dimensions of experience are interrelated, and as such modifiers of experience should not be siloed into individual dimensions. Patients may rate their care as excellent; however this result may provide a limited and optimistic view of their hospital experience. As patient-centred healthcare relies upon an understanding of what matters to the patient and family there is a need for a multidimensional approach in obtaining and utilising such information.

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