

A Concept Analysis of the Patient Experience in Acute Care

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Thesis Abstract

Background: Patient experience has become an essential quality indicator in healthcare.

Purpose: The purpose of this thesis was to conduct a concept analysis of the patient experience.

Methods: Walker and Avant's methodology served as the framework for this concept analysis.

Data were retrieved from seven databases and one search engine. The literature search used keywords related to "patient experience" and included articles published at any time up until March 2018. A total of 257 articles and organizational websites were included in the analysis after meeting the inclusion criteria.

Results: Twenty attributes were found to define the patient experience: communication, respect for patients, information/education, patient-centered care, comfort/pain, discharge from hospital, hospital environment, professionalism/trust, clinical care/staff competency, access to care, global ratings, medication, transitions/continuity, emotional dimension, outcomes, hospital processes, safety/security, interdisciplinary team, social dimension, and patient dependent features.

Conclusion: The results of this study will guide and clarify the critical concepts towards an explicit definition of the patient experience.

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Dedication

for Danijel

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Chapter One

Introduction

Introduction

Patient experience has come to the forefront as a main priority for healthcare organizations [1] and is recognized as one of the three pillars of quality healthcare along with safety and clinical effectiveness [2-5]. Literature shows that positive patient experiences improve care outcomes for patients [2, 5] and that patient experience is a commonly used term (e.g. Barron et al., 2007 [5]; Wolf et al., 2014 [6]; Doyle, Lennox & Bell, 2012 [2]). Patient experience has also been referenced in patient safety literature (e.g. Silvera, 2017 [7]; Nelson & Staffileno, 2017 [8]; Doyle, Lennox & Bell, 2012 [2]), controlling healthcare costs (e.g. Evan et al., 2017 [9]; Dempsey, Reilly, & Buhlman, 2017 [10]; Barron et al., 2007 [5]), and adherence to health-promoting behaviour (e.g. Greenfield et al., 1988 [11]; Zolnierek & Dimatteo, 2009 [12]; Anderson & Roy, 2012 [13]). Yet, the specific meaning of patient experience is poorly understood, and it remains vague and ambiguous due to a lack of consensus on a definition [14].

Relevance of Patient Experience

Patient experience is becoming an increasingly important priority in healthcare linked to improved clinical outcomes [2], improved adherence to medical advice [2], improved patient safety [2], and improved financial incentives [5, 10, 15]. Patient experience has an impact on clinical outcomes and future treatment goals and has been positively correlated with both the prevention and management of disease [15, 16]. For example, cardiac patients who reported a positive patient experience during hospitalization for myocardial infarction had better health outcomes a year after discharge [17, 18] and better inpatient mortality rates [19]. Another study showed a positive association between patient experience and patient outcomes for ulcer disease, hypertension, and breast cancer [20].

A positive patient experience was also linked with better adherence to medical advice such as the use of preventative services, (e.g. screening for diabetes, colorectal and breast cancer) [16, 19, 21], and better adherence to treatment plans [12]. Diabetic patients who reported a positive patient experience demonstrated improved self-management skills and reported a higher quality of life [11]. Furthermore, patients with depression demonstrated better adherence to antidepressants [13, 22], and cardiac patients demonstrated better adherence to clinical guidelines for acute myocardial infarction [19]. In a qualitative study conducted by Anderson and Roy, 2013 [13], 80 participants discussed their experiences with taking medications for depression. The study concluded that patient experiences with treatment had a significant impact on participants' decision to continue antidepressant medications and to follow the treatment plan [13]. Another study determined that regardless of age, if the patient's experience during treatment was not positive, it was unlikely that participants would continue treatment [22, 23].

Patient safety literature also references the patient experience [10, 24-26]. For example, one study found a positive association between patient experience and six-patient safety indicators: reduced decubitus ulcers rates, reduced hospital-acquired infections rates, reduced postoperative hemorrhage rates, decreased postoperative respiratory failure rates, reduced pulmonary embolism, and reduced sepsis rates [27]. A systematic review by Doyle and colleagues [2], which analyzed 55 studies in primary care and hospitals settings, showed positive associations between patient experience, patient safety and clinical effectiveness for a wide range of disease states, settings, outcome measures and study designs [2]. The outcome measures included both subjective and objective measurements of health status, physical health, mental health, overall well-being, and, the use of preventive health services, compliance or adherence to health-promoting behaviour, and resource use [2].

Significance of the study

A literature review showed a standardized definition of the patient experience does not exist, and those existing definitions do not consider many components from the patient experience measurement instruments. Wolf and colleagues [6] published a paper based on “a need to determine the extent to which clear and formal definitions exist, have common overarching themes, and/or have unique, but important constructs that should be considered more widely” (p.7). The authors examined 18 sources which included published articles and organizational websites with the objectives of identifying the main elements and themes in existing definitions of patient experience, summarizing the findings into a commonly shared definition, and identifying essential aspects which may be missing from the existing definitions. This study did not include operational definitions of the patient experience. Furthermore, the authors examined the term ‘patient experience’ but not the concept and lacked the use of a framework and systematic approach. Also, studies before the year 2000 were excluded despite the fact that the Agency for Healthcare Research and Quality (AHRQ) implemented the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for surveying the patient experience in 1995 [28-31]. Therefore, a comprehensive concept analysis is needed to achieve conceptual clarity and determine if the patient experience is truly a unique concept with its own defining attribute.

Purpose

The purpose of this thesis was to conduct a concept analysis of the patient experience. This involved the identification and the analysis of existing definitions, theories, and measures of patient experience to identify its defining attributes.

Personal Impetus

In Ontario, the Excellent Care for All Act [32] was created to improve the quality of care and value of the patient experience through application of evidence based healthcare. This act expects all hospitals in Ontario to meet certain objectives and compliance measures[32]. Working as a Registered Nurse in the Emergency Department (ED) I witnessed the creation of new roles and teams within the hospital with the goal of improving the patient experience. For example, the role of ‘Navigator’ was created to increase the patient flow within the ED in hopes of decreasing patient wait times and improving patient experience scores. Many changes were implemented in various capacities while using metrics to track progress. These metrics, for example, how long a patient waits before seeing a doctor, are routinely reported to the hospital staff and publicly on the hospital’s website.

Witnessing and participating in the healthcare changes implemented to improve the patient experience made me interested in the topic. I turned to the literature to search for strategies that other hospitals were using to improve their patient experiences and how nurses can contribute. I wanted to learn how nurses affected the patient experience and strategies I could use in my practice. During this search, I discovered the inconsistencies of defining and measuring patient experience, which led me to perform a concept analysis in search for conceptual clarity.

Thesis Outline

This thesis is composed of five chapters:

Chapter One includes the introduction to the thesis, background, significance of the study, and purpose of the study.

Chapter Two provides a detailed literature review of the patient experience, existing definitions, seminal works, patient experience seminal frameworks and tables for comparison.

Chapter Three describes the methodology of this thesis including study design, search strategy, literature screen, data extraction, synthesis, and the validity and rigour of the study.

Chapter Four is a structured manuscript entitled "A Concept Analysis of the Patient Experience in Acute Care" that will be submitted to Patient Experience Journal and includes the results of the concept analysis.

Chapter Five provides an integrated discussion regarding the patient experience in the acute care setting and its implications for nursing practice and research.

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Chapter Two

Literature Review

Literature Review

In this chapter, I will describe the literature reviewed to justify the need for a concept analysis of the patient experience. The overall aim of my literature review was to summarize the existing theoretical definitions of the patient experience and describe relevant patient experience frameworks.

Methods

Search Strategy

A comprehensive review of the literature in PubMed, MEDLINE and Cumulative Index to Nursing and Allied Health Literature (CINAHL) was completed using three sets of key search terms:

1. keywords related to the patient experience: “patient experience”, “inpatient experience”, “patient and family experience”, “patient experience framework”, “patient reported experience measures” and “patient reported outcome measures”;
2. keywords related to acute care: “tertiary”, “hospital”, “hospitals” and “secondary”;
3. keywords related to the population: “adult” and “adults”.

Additional search filters included studies in humans, English and French. The broad literature search was created in conjunction with a health sciences librarian. Covidence, a computer-based reference management software program, facilitated screening of title and abstract and the full-text of peer-review journal articles. A grey literature search of relevant websites (e.g. The Beryl Institute) and unpublished literature was completed using the search engine Google. Data extraction included patient experience definitions, frameworks or theories,

purpose and key considerations where available. Table 2.1 outlines the full search strategy for CINAHL, PubMed and MEDLINE.

Table 2. 1 Full Literature Review Search Strategy for CINAHL/PubMed/MEDLINE

<p>CINAHL: 1, 606 (TI("patient* experience*" OR "inpatient* experience*" OR "patient* and famil* experience*" OR "patient* experience* framework*" OR "patient* reported experience* measure*" OR "patient* reported outcome* measure*") OR AB("patient* experience*" OR "inpatient* experience*" OR "patient* and famil* experience*" OR "patient* experience* framework*" OR "patient* reported experience* measure*" OR "patient* reported outcome* measure*")) AND ((MH "Hospitals+") OR TI("tertiary" OR "hospital" OR "hospitals" OR "secondary") OR AB("tertiary" OR "hospital" OR "hospitals" OR "secondary")) AND ((MH "adult+") OR TI("adult" OR "adults") OR AB("adult" OR "adults")))</p> <p>PubMed: 11 (patient* experience*[tiab] OR inpatient* experience*[tiab] OR patient* and famil* experience*[tiab] OR patient* experience* framework*[tiab] OR patient* reported experience* measure*[tiab] OR patient* reported outcome* measure*[tiab]) AND (hospital[MESH] OR hospital[tiab] OR hospitals[tiab] OR tertiary[tiab] OR secondary [tiab]) AND (adult [MESH] OR adult [tiab] OR adults [tiab]) AND publisher [SB]</p> <p>Database: Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) <1946 to Present></p> <p>Search Strategy:</p> <hr/> <ol style="list-style-type: none"> 1 "patient* experience*".ti,ab. (47367) 2 "inpatient* experience*".ti,ab. (179) 3 "patient* and famil* experience*".ti,ab. (137) 4 "patient* experience* framework*".ti,ab. (197) 5 "patient* reported experience* measure*".ti,ab. (49) 6 "patient* reported outcome* measure*".ti,ab. (3172) 7 1 or 2 or 3 or 4 or 5 or 6 (50880) 8 exp hospital/ (248788) 9 Hospital.ti,ab. (830240) 10 Hospitals.ti,ab. (200895) 11 Secondary.ti,ab. (564804) 12 tertiary.ti,ab. (120743) 13 8 or 9 or 10 or 11 or 12 (1632748) 14 exp adult/ or adult.ti,ab. or adults.ti,ab. (6983462) 15 7 and 13 and 14 (6403)

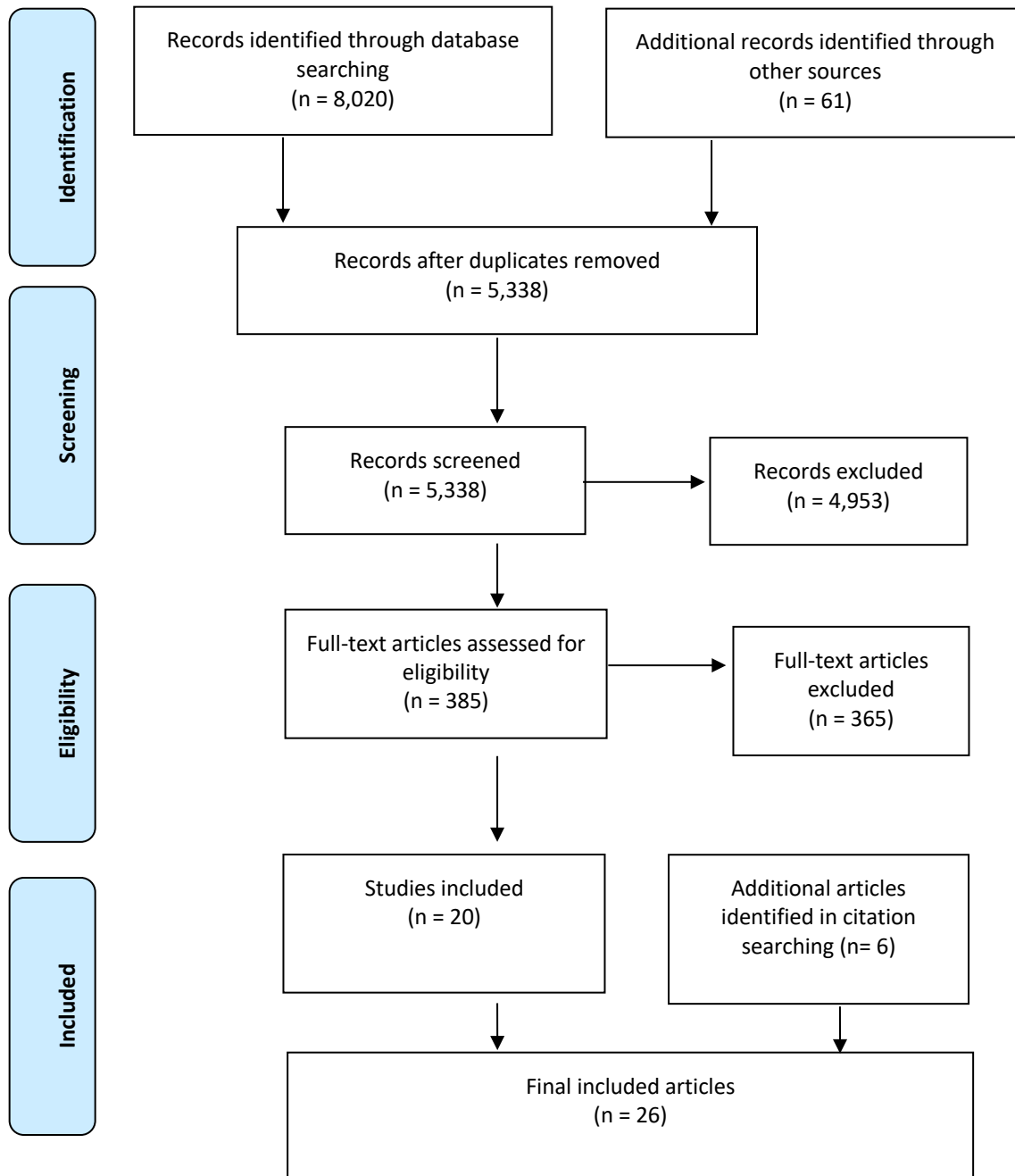
Results

Overview of Included Studies

The literature review search yielded a total of 8,085 articles, 8,020 from database searching, 61 from the search engine Google, and 6 articles from citation searching, including seminal literature (Figure 2.1). A total of 5,338 articles remained after removal of duplicates. After title and abstract screening, 385 articles proceeded to full-text screening. After full-text

exclusion (reasons listed in Figure 2.1) 20 remained, and 6 more articles were found through the citation search, resulting in 26 included articles.

Figure 2. 1 PRISMA Flow Diagram for Included Articles and Organizational Websites for the Literature Review



Reasons for Full Text Exclusion

- Not in English (N=13)
- Not a full article (abstract only; N=3)
- Wrong population (N=43)
- Wrong setting (N= 45)
- Patient experience used as a verb (N=93)
- No definitions of the patient experience, theory or framework (N=87)
- Patient experience not the main focus (N=81)

Definitions of Patient Experience

Although there is an apparent consensus on the importance of the patient experience there is also a noticeable lack of consensus regarding the definition of the patient experience from healthcare organizations [1, 2] and published literature [3-5]. Results of the 'Patient Experience Benchmarking Study' by The Beryl Institute demonstrated that only 45% of hospitals in the United States of America (USA) and 35% of hospitals outside the USA reported having a definition for patient experience [6]. Below, the results from my literature review are organized under theoretical definitions of the patient experience and patient experience frameworks.

Theoretical Definitions

Eight [1, 2, 6-11] out of the 26 articles contained an explicit definition of the patient experience, and two of those shared the same definition [2, 6]. Therefore, seven explicit definitions, in eight articles, of the patient experience emerged from the literature which is presented in Table 2.2.

Table 2.2 Literature Review Theoretical Definitions

Authors	Definition of the Patient Experience
Adventist Health System (2017) [1]	“Treating the patient as you would the person whom you love the most”.
The Beryl Institute (2010) [2] This definition is acknowledged and shared by Wolf and colleagues (2014)[6].	“The sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care”.
Bowling et al. (2012) [10]	“Patients’ experiences are their direct, personal observations of their healthcare.”
Stempniak (2013) [11]	“Let’s look at the patient experience in total as reducing suffering and reducing anxiety. And when you do that, you look across the entire continuum of care, from the first phone call to the patient’s being discharged.”

Feirn, Betts, & Tribble (2009) [7]	“The Patient Experience refers to the quality and value of all of the interactions—direct and indirect, clinical and nonclinical— spanning the entire duration of the patient/provider relationship”.
Robinson (2010) [8]	“Engaged healthcare is better healthcare, for everyone. And that's the best definition of the patient experience”.
Rudolph (2016) [9]	We define the patient experience as “everything we say and do that affects our patients’ thoughts, feelings, and well-being.”

Definitions from Healthcare Organizations

In the existing definitions from healthcare organizations, there are divergent views on what constitutes the exact definition of the patient experience. For example, the Adventist Health System [1] defines patient experience as "treating the patient as you would the person whom you love the most" (p.4) and identifies four critical factors for achieving high-level patient experience: making culture a top priority, engaging physicians, standardizing patient experience practices, and committing to meaningful use of data. While, The Beryl Institute [2] derived its definition of the patient experience from a review of research in 2010 along with a workgroup of healthcare leaders who identified essential aspects guiding their work around patient experience [6]. The authors grouped these ideas into four central themes: personal interactions, organizational culture, patient and family perceptions, and across the care continuum [6]. These four themes were used to develop the definition of patient experience by The Beryl Institute [2], which is "the sum of all interactions, shaped by an organization's culture, that influence patient perceptions, across the continuum of care" (p.1).

Continuum of Care and the Patient Experience

Several authors support The Beryl Institute’s [2] mention of “continuum of care” as an essential aspect of the patient experience (e.g., Wolf et al., 2014 [6]; Feirn, Betts & Tribble, 2009 [7]; Stempniak, 2013 [11]). Stempniak (2013) [11] states that care is measured across a

continuum and describes the patient experience as “...reducing suffering and reducing anxiety to the patient across the entire continuum of care, from first phone call to discharge”. Deloitte LLP’s Health Sciences Practice reinforces this by including “...the entire duration of the patient/provider relationship” [7] in their definition of the patient experience.

Patient Involvement and the Patient Experience

Other authors stress the importance of patient involvement in the patient experience. Robinson [8], from the Gallup Business Journal, states that to create the ideal patient experience, patients want four psychological elements fulfilled: confidence, integrity, pride, and passion. Robinson [8] claims that the focal point of patient experience is patient engagement stating "engaged healthcare is better healthcare, for everyone. And that's the best definition for patient experience"(p.1). Deloitte LLP's Health Sciences Practice concurs that patient involvement is important and refers to the patient experience as "the quality and value of all of the interactions- direct and indirect, clinical and non-clinical-spanning the entire duration of the patient/provider relationship" [7]. The authors stress that patient experience is not solely care based but includes the patient's interactions with the organization. While the National Health Service in England [12] does not define the patient experience, they provide eight statements describing what constitutes a good patient experience. One of these statements is: "I am involved as an active partner in my care-this means playing an active role, when I'd like to, in making decisions about my care, treatment and support, and being supported to look after myself day-to-day"(p.6). Rudolph [9] also recognized the importance of the patient's interaction with the organization but does not touch on patient involvement when he defined the patient experience as "everything we (hospital staff) say and do that affects our patients' thoughts, feelings, and well-being"(p.1).

Patient's Subjective Observations and the Patient Experience

Patient experience has also been referred to as the patient's subjective observation and expectations of their healthcare environment. Bowling and colleagues [10] conducted a review of patients' expectations of the healthcare they received and put forward a more succinct definition of patient experience as: "their direct, personal observations of healthcare" (p.1). Patients' expectations of care included cleanliness of the facility; information about managing their condition; coordination of care; convenient and punctual appointments; timely care; choice of doctor; friendliness of staff; doctor's competency; healthcare provider communication; patient engagement; patient's health outcomes; respect from doctors; being treated with dignity; receiving reassurance, advice, and information about health or condition; information about benefits/side effects of treatment; and receiving an opportunity to discuss problems [10].

Patient-Centered Care Culture

When a definition of patient experience is missing, authors often provide attributes that they consider essential to the concept. The importance of respect, dignity, and reassurance in the patient experience was outlined in an article about creating a sustainable ideal patient experience culture, where the authors stated that the ideal patient experience is formed through a patient-centered culture [13]. Similarly, the domains of patient experience defined by The Picker Institute [14] and the Institute of Medicine [15] are based on patient-centered care principles. According to the Institute for Health Care Improvement [16], the patient experience comprises of respect, partnership, shared decision-making, well-coordinated transitions, and efficiency.

Relational and Functional Aspects of the Patient Experience

Doyle and colleagues [17] identified aspects of patient experience by combining common elements from the patient experience frameworks used by the Institute of Medicine [15] by The

Picker Institute [14] and by The National Institute for Health and Care Excellence [18]. Doyle and colleagues [17] referred to the patient experience as an ambiguous term and acknowledged the importance of identifying and better explaining the concept by separating patient experience into two aspects: 'relational' and 'functional'. Relational aspects of the patient experience refer to interpersonal characteristics of care and mirror the 'respect for patient-centered values, preferences, and expressed needs' domain from the National Health Service Patient Experience Framework [19]; The Picker Institute's Patient-Centered Care Principles [14]; the Institute of Medicine's [15] six dimensions of patient-centered care; and Gerteis and colleagues' Eight Principles of Patient-Centered Care [20]. The functional aspects of the patient experience refer to how the care is delivered and includes issues such as timeliness, clean environment, and coordination between professionals [17]. The functional aspects mirror the remainder of the domains from the National Health Service Patient Experience Framework [19]; The Picker Institute's Patient-Centered Care Principles [14]; Institute of Medicine's [15] six dimensions of patient-centered care; and Gerteis and colleagues' Eight Principles of Patient-Centered Care [20].

Patient Experience Frameworks

Several frameworks have been developed to describe attributes of the patient experience and to provide a structure from which to approach the concept. Seven patient experience frameworks emerged from the literature: The Seven Dimensions of Patient-Centered Care [20], The Picker Institute's Eight Principles of Patient-Centered Care [14], The National Health Service Patient Experience Framework [19], The Picker Europe Core Domains of Patient Experience [21], The National Health Service of Wales Patient Experience Framework's Principles [22], Institute of Medicine's patient experience framework [15], and the Warwick Patient Experience Framework [23]. The majority of the frameworks stem from patient-centered

care principles. However, these frameworks are not comprehensive, lack a theoretical definition of the term ‘patient experience’, and lack research evidence for the domains they attribute to the patient experience (e.g., The Warwick Patient Experience Framework [23], National Health Service Patient Experience Framework [19], Institute of Medicine’s patient centered-care framework [15], Picker Institute’s Patient-Centered Care Principles [14]) [23]. Table 2.3 provides a summary of the following patient experience frameworks.

Gerteis and Colleagues (1993) Seven Dimensions of Patient-Centered Care

The work of Gerteis and colleagues [20] identified seven dimensions of patient-centered care: (1) respect for patient values, preferences and expressed needs; (2) coordination and integration of care; (3) information, communication, and education; (4) physical comfort; (5) emotional support and alleviation of fear and anxiety; (6) involvement of family and friends; and, (7) transition and continuity. The National Health Service Patient Experience Framework [19], Institute of Medicine’s patient centered-care framework [15], and, Picker Institute’s Patient-Centered Care Principles [14] all draw on the seminal publications by Gerteis and colleagues [20]. The dimensions from Gerteis and colleagues [20] were developed and based on three studies which measured the experience of hospital care by patients and families by interviewing 6455 patients and 2000 care-partners [24].

The Picker Institute’s Eight Principles of Patient-Centered Care

Researchers from the Picker Institute found specific practices conducive to a positive patient experience [25, 26] and gathered their findings to create the Picker's Eight Principles of Patient-Centered Care [25]. These eight principles of patient-centered were funded by the Picker/Commonwealth Fund patient-centered care program which began in 1986 [23] and are the

seven dimensions outlined by Gerteis and colleagues [20], with an added dimension of 'access to care' [23].

The Picker Institute Europe's Core Domains of Patient Experience

The Picker Institute Europe [21] assesses a patients' experience in acute care with respect to their experience in the following areas: (1) consistency and coordination of care; (2) treatment with respect and dignity; (3) involvement in decision; (4) doctors; (5) nurses; (6) cleanliness; and, (7) pain control. There is overlap with the domains of patient experience and the principles of patient centered-care, as shown below in Table 2.4.

National Health Service (NHS) Patient Experience Framework

The work of Gerteis and colleagues [20] also guided the creation of the National Health Service (NHS) Patient Experience Framework [19]. The National Health Service (NHS) Patient Experience Framework consists of eight dimensions: (1) respect for patient-centered values, preferences, and expressed needs; (2) coordination and integration of care; (3) information, communication, and education; (4) physical comfort; (5) emotional support; (6) welcoming the involvement of family and friends; (7) transition and continuity; and, (8) access to care [19].

The National Health Service Wales Patient Experience Framework's Principles

The National Health Service (NHS) Wales Patient Experience Framework [22] identifies five strategic principles which are vital to a positive patient experience in hospitals: (1) culture; (2) leadership; (3) safe-dignified care; (4) workforce; and, (5) the patient voice. The culture of an organization must focus on treating each person with dignity and respect [22]. The primary purpose of leadership and management is providing direction to develop culture and attitude that bring about change [22]. Safe-dignified care refers to not harming patients and ensuring a safe and clean environment for patients and family [22]. Workforce relates valuing staff member to

deliver excellent care [22]. Lastly, 'the patient voice' means listening to the patient to understand how to provide better care [22].

The Warwick Patient Experience Framework (WaPEF)

Uncertainty about the robustness of previously published patient experience frameworks (e.g., Institute of Medicine's (IOM) patient-centered care framework [15]; Picker Institute's Patient-Centered Care Principles [26]) inspired the Warwick Patient Experience Framework [23]. Staniszewska and colleagues [23] found limitations in the previous frameworks including uncertainty of how the dimensions were extracted from the research and the degree to which the frameworks reflected patient-identified experiences as opposed to those identified by researchers and clinicians. The Warwick Patient Experience Framework's [23] goal was to capture generic dimensions of patient experience and provide substantial evidence for each dimension. While the goal was to provide a generic framework of patient experience, researchers only included three clinical areas (cardiovascular disease, diabetes, and cancer patients) as part of their scoping review. They rationalized that these are the patients with conditions associated with significant disease burden, including chronic and acute patients, and are likely to have an array of health care experiences [23].

The Warwick Patient Experience Framework [23] provides a qualitative evidence synthesis to create themes observed in the literature by using the Institute of Medicine's [15] framework as a model against which to compare and contrast identified themes [23, 24]. The Warwick Patient Experience Framework [23] includes seven themes of patient experience: (1) patient as an active participant; (2) responsiveness of services - an individualized approach; (3) lived experience; (4) continuity of care and relationships; (5) communication; (6) information; and, (7) support [23].

The Institute of Medicine's framework

The Institute of Medicine's [15] framework consists of six themes (1) compassion, empathy and responsiveness; (2) coordination and integration; (3) information, communication and education; (4) physical comfort; (5) emotional support, relieving fear and anxiety; and, (6) involvement of family and friends [15, 23, 27]. Each dimension of the Institute of Medicine's [15] framework was broken down to explore whether each category could stand alone, for example, in one case, information and communication were separated into two groups [23].

Continued Comparison of the Patient Experience Frameworks

The significant difference between the Institute of Medicine's [15] framework and WaPEF [23] is the consideration of patients as active participants in their care. Another difference is that The Warwick Patient Experience Framework [23] stresses the importance of the theme 'lived experiences' as underpinning health service experiences. The dimension 'lived experience' is considered particularly important as it recognizes that each person experiences his or her condition a unique way [23]. The definition of 'lived experience' encompasses everyday experiences, hopes, expectations, future uncertainty, feelings of loss, feelings of being morally judged, and feelings of blame [23]. This dimension is considered particularly important as it recognizes each person uniquely and identifies that some of the experiences originate outside of the healthcare system and are brought with the patients into the health system [23].

The Guideline Development Group (GDG) believed the Institute of Medicine's [15] framework and The Picker Institute's [26] principles were influenced by the hospital setting in which they were developed and considered, and that the Warwick Patient Experience Framework [23] has better validity and encompasses more issues [18, 23]. The GDG decided to use The Warwick Patient Experience Framework to form the Patient Experience Guidance [23, 24].

However, the Guideline Development Group did not consider the theme 'lived experiences' as useful because they found it challenging to use for developing recommendations [18, 23].

Additionally, the Guideline Development Group thought about aspects of care that did not appear in The Warwick Patient Experience Framework such as nutrition and access to food [18, 23].

While the physical environment is important in many frameworks (e.g., The Warwick Patient Experience Framework [23], The Picker Institute's Patient-Centered Care Principles [26];

Institute of Medicine [15] patient-centered care framework), the researchers focused on clinician and patient interaction, and organizational issues, but omitted the physical environment due to the timeframe of The Warwick Patient Experience Framework's scoping review, [18, 23].

Table 2.3 Summary of Patient Centered Care and Patient Experience Framework's Purposes and Considerations

Framework	Warwick Patient Experience Framework	Institute of Medicine's 'Crossing the Quality Chasm: A New Health System for the 21st Century' (2001) Framework for a new Health System	NHS's Patient Experience Framework	The Picker Institute's Eight Principles Patient-Centered Care	Gerteis and colleagues (1993) Seven Dimensions of Patient-Centered Care
Definition	None provided	None provided	None provided	None provided	None provided
Purpose	To capture generic dimensions of patient experience and provide substantial evidence for each.	<p>Focused specifically on the improvement of health care services to individuals.</p> <p>"For this reason, we describe the six aims for improvement from the perspective of the individuals usually a patient's- experience" (p.44, 2001).</p>	To explain what NHS means by "experience of care."	To explore what it will take to achieve more rapid and widespread implementation of patient-centered care in both inpatient and ambulatory healthcare settings.	To define patient-centered care and list dimensions considered important for patient-centered care.
Key Considerations	<p>The Warwick Patient Experience Framework is the first patient experience framework with an explicit link to an underpinning patient evidence base, linking themes and sub-themes with specific references.</p> <p>This framework was used to inform the development of NICE Guidance and Quality Standard 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services'.</p>	<p>The review did NOT include publications based on reports of patient experience.</p> <p>Goodrick and Cornwell (2008) conducted a literature review that mapped out the Institute of Medicine's framework and discovered the evidence is full of gaps especially for dimensions of involvement of family and friends, and physical comfort.</p> <p>Influenced by the hospital setting which it was developed in.</p> <p>The limitation cited by Staniszewska and colleagues (2014) of the framework include</p>		<p>Influenced by the hospital setting, which it was developed in.</p> <p>The limitation cited by Staniszewska and colleagues (2014) of the framework include uncertainty about how the dimensions were extracted from the research, the degree to which the frameworks reflected patient-identified experiences as opposed to those identified by researchers and clinicians</p>	

	<p>Failed to research physical environment due to time constraints.</p> <p>While the goal was to provide a generic framework of patient experience, researchers only included three clinical areas (cardiovascular disease, diabetes, and cancer patients) as part of the scoping review.</p> <p>Missing aspects of care such as nutrition and access to food.</p>	<p>uncertainty about how the dimensions were extracted from the research, the degree to which the frameworks reflected patient-identified experiences as opposed to those identified by researchers and clinicians (Staniszewska et al., 2014).</p>		<p>(Staniszewska et al., 2014).</p>	
	<p>The major difference between Institute of Medicine's framework and The Warwick's Patient Experience Framework is the consideration of patients as an active partner in their care (Staniszewska et al., 2014).</p>	<p>Institute of Medicine's six dimensions of patient-centered care are based off Gerteis and colleagues' (1993) 7 principles of patient-centered care. Institute of Medicine amalgamates dimension 7 (transition and continuity) with dimension 2 (co-ordination and integration of care).</p>	<p>The NHS framework is based on the Picker Institute's 8 principles of PCC.</p>	<p>The Picker Institute uses the 7 dimensions outlined by Gerteise and colleagues (1993) and adds an 8th principles: access to care.</p>	
		<p>The NHS Patient Experience Framework (2012), the Institute of Medicine's six key dimensions of patient-centered care (2001), and the Picker Institute's Patient-Centered Care Principles (2007) all draw on the seminal work by Gerteis and colleagues (1993).</p>			

Table 2. 4 Summary of Domains for Patient Centered-Care and Patient Experience Frameworks

<p>Seven Dimensions of Patient-Centered Care (Gerteis et al., 1993)</p>	<p>The Picker Institute's Eight Principles of Patient-Centered Care (Shaller, 2007)</p>	<p>NHS Patient Experience Framework (NHS, 2011)</p>	<p>The Picker Europe (2009) Core Domains of Patient Experience (Sizmur & Redding, 2009)</p>	<p>The NHS Wales Patient Experience Framework's Principles (2012) (NHS Wales, 2012)</p>	<p>Institute of Medicine (Institute of Medicine, 2001)</p>	<p>Warwick Patient Experience Framework (Staniszewska, 2014)</p>
<p>Respect for patient values, preferences and expressed needs</p>	<p>Respect for patient values, preferences</p>	<p>Respect for patient-centred values, preferences, and expressed needs, (including: cultural issues; the dignity, privacy and independence of patients and service users; an awareness of quality-of-life issues; and shared decision making)</p>	<p>Treatment with respect and dignity</p>	<p>Culture The culture of the organization must be one of valuing every person and ensuring that they are treated with dignity and respect.</p>	<p>Compassion, empathy and responsiveness</p>	<p>Patient as active participant</p>
<p>Coordination and integration of care</p>	<p>Coordination and integration of care</p>	<p>Coordination and integration of care (across the health and social care system)</p>	<p>Consistency and Coordination of Care</p>	<p>Leadership The key purpose of leadership and management is to provide direction, gain commitment, facilitate change and achieve results through the</p>	<p>Coordination and integration</p>	<p>Responsiveness of services- an individualized approach</p>

				<p>efficient, creative and responsible deployment of people and other resources. Integral to this is not only the ability to work with a broad range of staff and external partners, but to develop the culture and attitude that facilitate work with patients and service users to bring about change.</p>		
<p>Information, communication, and education</p>	<p>Information and education</p>	<p>Information, communication, and education (on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care and health promotion)</p>	<p>Doctors</p>	<p>Safe Dignified Care This means that we do no harm to patients, by ensuring that the environment is safe and clean and by reducing avoidable harm. It also means that we give patients more control over their own care, and care for every patient in the way we would want our family, friends and loved ones to be cared for.</p>	<p>Information, communication, and education</p>	<p>Information</p>
<p>Physical comfort</p>	<p>Physical comfort</p>	<p>Physical comfort</p>	<p>Pain control</p>	<p>Workforce</p>	<p>Physical comfort</p>	<p>Lived experience</p>

		(including pain management, help with activities of daily living, and clean and comfortable surroundings)		We will trust, skill-up and enable our staff to deliver excellence, valuing them and their contribution.		
Emotional support and alleviation of fear and anxiety	Emotional support	Emotional support (and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances)	Nurses	“The Patients Voice” This means listening to our patients and carers, as individuals and collectively, to understand how we can better provide patient centred services.	Emotional support-relieving fear and anxiety	Communication
Involvement of family and friends	Involvement of family and friends	Welcoming the involvement of family and friends, (on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as care-givers)	Involvement in decision		Involvement of family and friends	Continuity of care and relationships
Transition and continuity	Continuity and transition	Transition and continuity	Cleanliness			Support

		<p>(as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions)</p>				
	<p>Access to care</p>	<p>Access to care (with attention for example, to time spent waiting for admission or time between admission and placement in a room in an in-patient setting, and waiting time for an appointment or visit in the out-patient, primary care or social care setting)</p>				

Content Analysis

Comparing Theoretical Definitions and the Patient Experience Frameworks

Four [1-4] of the eight articles containing an explicit definition mentioned ‘continuum of care’ in their definition of the patient experience. ‘Continuum of care’ was not present in any of the frameworks as an aspect of the patient experience and was solely found in the explicit definitions.

‘Personal interaction’ and ‘patient engagement’, the strongest theme across the articles, are present in 18 [1-3, 5-18] of the 26 articles (69%). ‘Culture’ as an aspect of the patient experience was mentioned in six articles [2, 3, 17-19] of the 26 articles (23%) including the NHS Wales Patient Experience Framework [20]. ‘Culture’ was not present in any of the other frameworks.

Showing ‘respect for patient values and preferences’ was the most frequent characteristic across the frameworks as it appeared in all seven. Surprisingly, respect was not present in any of the explicit definition of the patient experience. ‘Coordination and integration of care’ was present in five [8, 9, 12, 13, 21] of the seven frameworks but is not mentioned in any of the explicit definitions of the patient experience.

Many aspects of the patient experience were present in the frameworks but were not mentioned in the explicit definitions, these include ‘emotional support’, ‘involvement of friends and family’, ‘transitions and continuity’, ‘physical comfort’ and ‘access to care’.

Summary of the Literature Review

In this literature review, I sought to find explicit definitions and frameworks of the patient experience. Overall, this literature review demonstrates the lack of consistency and clarity regarding the definition of the patient experience among institutions and published literature. The majority of the patient experience frameworks stem from patient-centered care principles. These frameworks lack a definitions of the patient experience, are not comprehensive and lack research evidence for the domains they attribute to the patient experience (e.g. NHS Patient Experience Framework [21], Institute of Medicine's patient centered-care framework [9], Picker Institute's Patient-Centered Care Principles [12]) [14].

Furthermore, this literature review presents large discrepancies between authors who present an explicit definition of the patient experience and those who provide a patient experience framework. For example, 'continuum of care' and 'culture' were mentioned frequently in the explicit definitions but were absent from all frameworks. 'Respect for patient preferences' was the most frequent across all seven of the frameworks but missing from all other sources. Other aspects of the patient experience such as 'emotional support', 'involvement of friends and family', 'transitions and continuity', 'physical comfort', and, 'access to care' were all mentioned numerous times in the frameworks but were absent from explicit definitions. The results of this literature review further confirm the need for a concept analysis of the patient experience to identify its defining attributes and provide conceptual clarity.

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Chapter Three

Methodology

Methods

In this chapter, I present the methodology used for the concept analysis, including study design, search strategy, screening literature, data extraction, synthesis, ethical considerations, as well as validity and rigour.

Concept Analysis Methodologies

There are specific methods to define concepts for research which depend on the researcher's beliefs and approach of the concept [1]. A concept analysis enables knowledge development and enhances communication in research and clinical practice about a particular concept [1]. To select the concept analysis methodology most congruent with the goals of this thesis, first, various concept analysis methodologies were reviewed.

Norris' [2] method of concept analysis is focused on developing meaningful descriptions of phenomena in nursing which contribute to the development of concepts. Norris [2] does not discuss the influence of context and time on concepts, yet, includes the participant observation technique as part of the process. While Norris' method consists of five succinct steps, there is a lack of information and guidance on applying the steps [2]. The theory construction of Norris's concept analysis did not fit the goals of my thesis and the participant observation approach was not feasible within the time limits of this thesis.

Rodgers' [3] evolutionary view of concept analysis is founded on relativism which views concepts as dynamic and evolving, without clear boundaries [3]. Rodgers' method consists of eight clearly outlined steps with the use of inductive analysis [3]. According to Rodgers [3], concepts are not static as they are influenced by contextual factors and evolve and change over time. While the purpose and method of Rodgers' evolutionary view of concept analysis were generally congruent with the goals of this thesis, it was not the most congruent philosophically.

Walker and Avant's [4] method of concept analysis is based on ontological realism, with a philosophical view that concepts are static entities, independent of context and time, with clear and distinct boundaries. Since the concepts have identified meanings, they can be measured and assessed empirically. Walker and Avant [5] describe the eight steps clearly and stress the centrality of literature review to the concept analysis methodology. Walker and Avant's [5] concept analysis methodology was chosen as it was the most congruent with the goals and purpose of this thesis.

Study Design

This study was conducted using Walker and Avant's [5] concept analysis methodology to provide a systematic approach to distinguishing the defining attributes of the patient experience. Walker and Avant's [5] methodology guided numerous concept analyses within the nursing discipline (e.g., Liu et al., 2014 [6]; ; Keenan, 1999 [7]; Fischer, 2016 [8]; Xyrichis & Ream, 2008 [9]). The described approach in Walker and Avant's [5] method of concept analysis consists of eight iterative steps: (1) selecting a concept, (2) determining the aims and purpose of analysis, (3) identifying all uses of the concept, (4) determining the defining attributes, (5) constructing a model case, (6) constructing borderline and contrary cases, (7) identifying antecedents and consequences, and, (8) defining empirical referents. A summary of the steps is available in Appendix A.

Search Strategy

Conducting a review of the existing literature on this topic served to validate my motivation for performing this concept analysis on the patient experience. This preliminary review served several purposes. First, it aimed to determine if the concept of patient experience

has been explicitly defined and if there is consensus on a definition within the healthcare literature. Second, it sought to determine a foundation, scope and use of the term patient experience and its related concepts in the literature. Third, it sought to review possible analytic approaches to defining the term. The preliminary search confirmed no standardized definition of the patient experience currently exists; therefore, the next step was beginning the concept analysis by performing a comprehensive literature search.

The search strategy started with searching only bibliographic databases using the inclusion criteria. Databases PubMed, MEDLINE, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Cochrane Database of Systematic Reviews, Nursing and Allied Health, EMBASE, and ABI Inform Collection were searched for the term “patient experience,” “patient and family experience,” “patient reported experience measure,” “patient reported experience measures” and “patient care experience,” in the title and/or abstract for the initial search.

In conjunction with a librarian from the University of Ottawa, I developed the search criteria, and feasibility reasons limited the search terms to the five mentioned terms. A search was conducted using each search term: “patient experience,” “patient and family experience,” “patient reported experience measure,” “patient reported experience measures” and, “patient care experience.” The rationale for conducting individual term searches was that during the preliminary search, all of the terms were searched simultaneously with “or” separating them, which resulted in fewer articles than individual term searches. Specific Medical Subject Headings (MeSH) terms for patient experience do not exist in any of the databases searched.

Two librarians conducted the Peer Reviewed Electronic Search Strategy checklist (PRESS) [10] and the second librarian suggested adding proximate subject headings “patient satisfaction” and “patient-centered care,” as well as using truncation and proximity to capture

variations and synonyms of the patient experience. While this would have resulted in an increased sensitivity of the search and would have reduced the risk of missing potentially relevant results, the search results were unfeasible for a master's thesis. With the included recommended changes, the search strategy resulted in 133,711 articles in the Medline database alone (Table 3.1). Search terms such as “patient perspective,” “patient opinion,” and “patient measure” were not included in the search strategy due to the unfeasibility of the results. Additionally, for my thesis, I only analyzed the patient experience as a single concept and not as part of a multi-concept search strategy. Analyzing the reference lists from the research proposal during the PRESS review (Appendix B), revealed a few variations of patient experience in titles of documents not captured in the search strategy which resulted in the addition of the “patient care experience” as an additional term to increase the search sensitivity.

Table 3. 1 Preliminary Search Results in MEDLINE

MEDLINE database search terms, which are synonymous to patient experience:

- 1 Patient-Centered Care/ (16375)
- 2 Patient Satisfaction/ (77347)
- 3 (patient adj3 experience*).tw. (23369)
- 4 (patient adj2 perspective*).tw. (3615)
- 5 (patient adj2 opinion*).tw. (576)
- 6 (patient adj3 measure*).tw. (20346)
- 7 or/1-6 (133711)

The ABI Inform Collection database assisted in searching for healthcare administration articles about the patient experience. The titles and abstracts of the articles (or full text when the

abstract was not available) from the search results were scanned to identify articles that used the term patient experience within the article. The full-text of included articles were then reviewed to determine which ones utilized the patient experience as an autonomous concept, a central topic of the article, as a variable of study, or as a key concept that was defined, described, or developed explicitly (Table 3.4). The remaining articles comprised the concept analysis. Table 3.2 provides a detailed search strategy for each database.

Furthermore, to search for grey literature, references of key articles included in the concept analysis were searched, a search for unpublished reports such as dissertations and theses (using ProQuest) was conducted, and the search engine Google, was used to find organizational websites. The ProQuest platform was used to search ABI Inform Collection, Nursing and Allied Health Databases, and ProQuest Dissertations and Theses. The ProQuest platform search of ABI Inform Collection and Nursing and Allied Health Databases was limited to scholarly articles. The grey literature search using the ProQuest platform to ABI Inform Collection, Nursing and Allied Health Databases, and ProQuest Dissertations and Theses was limited to reports, dissertations and theses, and working papers.

Google is an effective way to search websites, which may contain information about the patient experience or may have a definition of the patient experience. Examples of websites include the Agency for Healthcare Research and Quality [11], the Canadian Institute for Health Information [12], The Beryl Institute [13], the Patient Experience Summit [14], and the Forbes Magazine [15]. A modified version of the effort bounded guideline [16] which consists of searching the top 100 webpages served as the strategy for searching Google; the search stopped as nothing was relevant on the three final and consecutive pages. Since nothing was relevant for three consecutive pages, it was likely that the information would continue to be irrelevant.

Google provides information based on relevance; therefore, the theory is the farther away from page one, the less relevant the information is.

Table 3. 2 Search Strategy

No subject term (MESH heading) exists in any of the listed databases, hence, the listed databases can only usefully be searched at the title and abstract level.

CINAHL:

(ti. "patient experience" OR "patient and family experience" OR "patient reported experience measure" OR "patient reported experience measures" OR "patient care experience") OR (ab. "patient experience" OR "patient and family experience" OR "patient reported experience measure" OR "patient reported experience measures" OR "patient care experience")

PubMed:

["patient experience".ti,ab OR "patient and family experience".ti,ab OR "patient reported experience measure".ti,ab OR "patient reported experience measures".ti,ab OR "patient care experience".ti,ab.] AND publisher [SB]

To search PubMed for articles which are NOT available as part of the Medline search "publisher [SB]" is added at the end of the search.

Ovid Platform

Medline:

1. "patient experience".ti,ab.
2. "patient and family experience".ti,ab.
3. "patient reported experience measure".ti,ab.
4. "patient reported experience measures".ti,ab.
5. "patient care experience".ti,ab.

Each line was searched individually then the results were combined with "OR".

Cochrane:

1. "patient experience".ti,ab
2. "patient and family experience".ti,ab
3. "patient reported experience measure".ti,ab
4. "patient reported experience measures".ti,ab
5. "patient care experience".ti,ab

Each line was searched individually then the results were combined with "OR".

EMBASE:

1. "patient experience".ti,ab
2. "patient and family experience".ti,ab
3. "patient reported experience measure".ti,ab
4. "patient reported experience measures".ti,ab
5. "patient care experience".ti,ab

Each line was searched individually then the results were combined with "OR".

ProQuest Platform

ABI Inform Collection:

(ti. "patient experience" OR "patient and family experience" OR "patient reported experience measure" OR "patient reported experience measures" OR "patient care experience") OR (ab. "patient experience" OR "patient and family experience" OR "patient reported experience measure" OR "patient reported experience measures" OR "patient care experience")

Limited to scholarly articles.

Nursing and Allied Health:

(ti. "patient experience" OR "patient and family experience" OR "patient reported experience measure" OR "patient reported experience measures" OR "patient care experience") OR (ab. "patient experience" OR "patient and family experience" OR "patient reported experience measure" OR "patient reported experience measures" OR "patient care experience")

Limited to scholarly articles.

Grey Literature Search Using ProQuest Platform

ProQuest Dissertations and Theses:

(ti. "patient experience" OR "patient and family experience" OR "patient reported experience measure" OR "patient reported experience measures" OR "patient care experience") OR (ab. "patient experience" OR "patient and family experience" OR "patient reported experience measure" OR "patient reported experience measures" OR "patient care experience")

Limited to reports, dissertations and theses, working papers, and, conferences and proceedings.

Grey Literature Search Using Google Search Engine

Google:

1. "patient experience"
2. "patient and family experience"
3. "patient reported experience measure"
4. "patient reported experience measures"
5. "patient care experience"

Each term was conducted individually during a preliminary search with all of the terms together with "or" separating them, the results revealed less articles than conducting the search with individual term used separately.

Inclusion and Exclusion Criteria

Inclusion Criteria

The inclusion criteria consisted of studies written in English and French, but not limited to Canadian literature since English and French-speaking countries share terminology. The country of article origin was included in the data extraction sheet as it provided an opportunity to make comparisons between countries. Research studies of any study design were included, and articles such as literature reviews, and scholarly commentaries, were also considered. For the full-text screen, articles, which used the term patient experience in an autonomous, or meaningful way, rather than as a replacement for an active verb, were included. Patient experience may serve as a verb or as a synonym in a sentence versus acting as an autonomous concept. Patient experience can act as a synonym for “encounter” or “undergo,” for example, “patient experiencing surgery” instead of “patients undergoing surgery” or “patient experiencing harassment” instead of “patient facing harassment.” In these examples, the patient experience was not considered an autonomous concept as it served as a synonym and expressed as a verb.

Exclusion Criteria

Exclusion criteria consisted of articles that were not in the English or French language and those that did not contain the term “patient experience” within the article. Only studies using the term patient experience were considered; searching for terms used as synonyms for patient experience produced too large of a search result, as demonstrated in the preliminary search in Table 3.1. Table 3.3 provides the inclusion and exclusion criteria during the title and abstract screening, and Table 3.4 provides the additional inclusion and exclusion criteria during full-text screening.

Table 3.3 Inclusion and Exclusion Criteria During Title and Abstract Screening

Inclusion in Title or Abstract	Exclusion in Title or Abstract
Contains the term or some variation of the terms "patient experience" or, "patient and family experience" or, "patient care experience" or, "patient reported experience measure" or, "patient reported experience measures".	Articles discussing terms which are not patient experience, such as patient satisfaction, or patient engagement, etc.
Any study designs including dissertations.	Conference proceedings.
Written in the English or French languages.	Written in a language other than English or French.
Patient's experience with interactions in the healthcare environment.	<p>Patient's experience with a particular disease or experience focused on a particular medical procedure (and only about this procedure).</p> <p>Example 1: An article examining the patient's experience with various clamping methods to surgical treatment of hepatobiliary diseases.</p> <p>Example 2: Article solely discussing patient's experience with IV insertion in hand versus forearm etc.</p> <p>Example 3: Patient's experience with a diabetic infusion set.</p>
Acute care setting.	All settings other than the acute care setting.
Adult population (>18years of age).	Pediatric population.

Table 3.4 Additional Inclusion and Exclusion Criteria During Full- Text Screening

Additional Inclusion in Full Text	Additional Exclusion in Full Text
Contains the term "patient experience" or a variation of the term either <ul style="list-style-type: none"> ○ defined ○ as a variable in the study ○ as the subject 	Studies that do not contribute any relevant information.
Contains the term patient experience as an autonomous concept.	The term patient experience is present but serves as a verb or a synonym versus acting as an autonomous concept. Example 1: Patients experience superior weight loss (verb). Example 2: Bowel prep is not a positive patient experience (verb). Example 3: Entonox may be used to improve patient experience during colonoscopy.
Provide a description of patient experience.	
Provides a framework of patient experience.	
Published in any country.	
Any articles lacking an abstract automatically proceed to full-text screening.	
Articles which include any type of patient experience instrument.	
Any article that may contain information relevant to the measurement of patient experience or containing relevant information about the measurement of patient experience.	

Screening Literature

The results from each database were uploaded into reference manager software (Endnote) and duplicates removed using Bond University Centre for Research in Evidence-Based Practice-Systematic Review Assistant Deduplication Module (CREBP-SRA-DM) [17] as it was shown to have higher specificity and sensitivity than EndNote. The first search resulted in 19,126 references, which decreased to 12,676 after the de-duplication process. A computer-based reference management software program (Covidence) served for citation screening, abstract review, full-text review, eligibility (study selection) and data export. Two reviewers independently screened the identified literature.

When the reviewers came across studies that they were unsure whether to include or exclude based on the title and abstract; the study proceeded to full-text screening. When disagreements occurred, a discussion between the two reviewers took place to reach consensus, and if necessary, a third reviewer was used to resolve any disparities. Search findings were documented using Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) [18] and include the reasons for exclusion of all full-text articles. Appendix C contains a working definition for each of the five search terms, which acted as a guide during screening.

Data Extraction

Data extraction was performed using an Excel spreadsheet by one reviewer and independently verified by a second reviewer. Walker and Avant's [5] steps serve as a guide to the data extraction process. Findings from each article were extracted into categories using the Walker and Avant's [5] concept analysis method approach. This iterative approach allowed the

addition of categories as data extraction progressed. Information from relevant studies was extracted into matrix tables to organize the literature and data extraction. A methodological matrix was used in an Excel document to record features of the studies such as the population, setting, definition, and identified domains of patient experience, and data needed for the eight-step Walker and Avant's [5] concept analysis method. The data extraction process also included screening for related terms including surrogate terms (synonyms) and associated terms (terms that share some attributes with the concept). Endnote was used to keep track of all the references.

Data Synthesis

Provided are the data synthesis and a narrative review of the findings. Each article was read numerous times and relevant information was extracted into Excel sheets. In the first Excel sheet, data extraction categories included the author(s), title, study design, country, type of hospital, setting, methods, data collection, antecedents, consequences, theoretical definition(s), operational definitions(s), instruments, and, framework or theory used. In a second Excel sheet, the theoretical and operational definitions were further broken down and extracted. Each question from patient experience instruments mentioned in the articles were broken down into components and extracted into individual categories. Theoretical definitions were broken down and extracted into the same categories as the instruments. Then, synonyms of the individual categories were assessed and combined appropriately after review and approval by the thesis committee. These categories were arranged into appropriate titles for features, then further organized and clustered into attributes. The list of attributes was further assessed, synonyms combined, analyzed, organized and clustered into the final twenty attributes with review and approval by the thesis committee. Lastly, the twenty attributes were then combined into themes to create a succinct definition of the patient experience.

To ensure an unbiased interpretation of the data two independent reviewers verified the identification of attributes, antecedents, and consequences. Any attributes not noted by one reviewer were discussed between the two reviewers and added if appropriate. The reviewers reread the articles until data saturation occurred for the attributes, antecedents, and consequences. The antecedents and consequences underwent a similar assessment and reorganization into themes when applicable. Insights gained during data collection were written in a journal, to avoid drawing premature conclusions and impression of data saturation before the formal analysis.

Ethical Considerations

Since the introduction of the Nuremberg Code (1949) [19] and the Declaration of Helsinki (1964) [20], the place of ethics in research has been vital. For concept analyses, ethics approval is not required due to the secondary nature of the analysis [21]. It is accepted in practice that the original studies respected the fundamental criteria of ethics [21]. The methodology used for secondary analyses encourages an exhaustive search of data including unpublished data, making it possible for unethical studies to be included [21].

Validity and Rigour

For this thesis, validity and rigour were considered during all steps of the process. To guarantee the validity, the purpose and objectives of this thesis were defined, and, two reviewers screened all literature independently to determine whether they fit the inclusion criteria. Internal validity refers to the extent to which the research findings are an accurate reflection of reality, and external validity refers to the degree in which the research findings are legitimately applicable across groups [22]. The experts on my committee examined and decided if I was achieving what I intended to accomplish during my thesis and provided regular feedback.

Analysis verification by a second, independent reviewer and review of the literature validated the appropriateness of the defining attributes.

Rigour was supported throughout the process by review of committee members in collaboration with me (the primary researcher). A systematic approach was used to conduct the concept analysis to ensure study rigour. The search strategy was developed by an experienced librarian, and reviewed independently by a second librarian using the Peer Reviewed Electronic Search Strategy checklist [PRESS] [10]. Reliability of research refers to the ability of the research methods to yield consistently the same results repeatedly [23]. To improve reliability, Walker and Avant's [5] method of concept analysis served as a guide. To ensure credibility throughout the analysis, the researcher kept an audit trail of work processes, decisions, and interpretations.

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Chapter Four

A Concept Analysis of The Patient Experience in Acute Care

This chapter is a version of the manuscript formatted for submission to the Patient Experience Journal.

Title: A Concept Analysis of The Patient Experience in Acute Care

Running title: A Concept Analysis of The Patient Experience

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Abstract

Purpose. The purpose of this study was to conduct a concept analysis of the patient experience in the acute care setting. This involved the identification and the analysis of existing definitions, theories, and measures of the patient experience to identify its defining attributes.

Design: Walker and Avant's eight-step methodology served as the framework for this concept analysis.

Background: Patient experience is an essential indicator of quality care, and hospitals are interested in maintaining positive patient experience metrics to stay competitive in the healthcare business.

Data sources: A literature search using seven databases (PubMed, MedLine, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Cochrane Database of Systematic Reviews, Nursing and Allied Health, EMBASE, ABI Inform Collection) and one search engine (Google) was conducted of existing literature published any time up until March 2018. The initial search identified 12,676 references of which 257 articles and organizational websites were included.

Results: Patient experience is defined in a variety of ways through the use of operational and theoretical definitions. A total of twenty attributes were found to define the patient experience: (1) communication; (2) respect for patients; (3) information and education; (4) patient-centered care; (5) comfort and pain; (6) discharge from hospital; (7) hospital environment; (8) professionalism and trust; (9) clinical care and staff competency; (10) access to care; (11) global ratings (12) medication; (13) transitions and continuity; (14) emotional dimension; (15) outcomes; (16) hospital processes; (17) safety and security; (18) interdisciplinary team; (19) social dimension; and, (20) patient dependent features. These attributes were shown to be comprehensive across countries and hospital settings.

Conclusion: Our findings identified comprehensive attributes of the patient experience for healthcare researchers and hospital policymakers to consider in respect to an explicit definition of the patient experience.

Keywords: patient experience; patient and family experience; patient reported experience measure; patient reported experience measures; patient care experience

Introduction

As healthcare shifts from a disease-centered to a patient-centered model [1] the concept of patient experience assumes a crucial role. The imperative to improve patient experience is rooted in clinical and business motives [2, 3]. Clinical motives include improved patient health outcomes, better adherence to medical advice, improved patient safety, and better prevention and management of disease [2, 4-10]. Business motives include financing and reimbursements, increased profitability [6] and reduced medical malpractice risk [11].

Globally, changes to government healthcare policies, public reporting of patient experience survey scores, coupled with value and performance-based incentives and reimbursements have led the growing impetus of improving the patient experience within healthcare [2, 3]. In the literature, hospitals in the United States with the highest patient experience scores were the most profitable [12], and physicians had higher patient retention rates [13]. In Canada, the Ministry of Health and Long-Term Care reinforced the significance of patient experience in Ontario's healthcare through The Excellent Care for All Act (2010) [14], which requires hospitals to establish patient relations processes to improve the patient experience and serves as the foundation for monetary reimbursement.

The growing impact of positive patient experience scores for hospitals has made it essential to have a consensus on what constitutes the patient experience and how it is measured globally.

Need for a Definition and Concept Analysis

There is an apparent consensus on the importance of the patient experience in healthcare but a lack of agreement about what constitutes the patient experience. Although the patient experience has been studied and measured, there is a noticeable lack of explicit

definition of the term in published literature, and when definitions are provided, there is a lack of consistency [15-17]. This confusion leads to difficulties in determining whether different authors are making similar assumptions about what constitutes the "patient experience" and whether the authors are referring to the same concept [15, 17]. Additionally, while the existing definitions attempt to create a unique understanding of the term, they fail to capture the breadth of the issues and only form a part of the full concept by not incorporating many components from patient experience measurement instruments.

Although it is a commonly used term in research and clinical practice [3, 5, 18], the patient experience remains an ambiguous concept with a wide range of interpretations and measures [3]. Literature related to the patient experience, including systematic reviews, is often limited due to a lack of consensus on the definition (e.g., McMurray et al., 2016 [19]; Johnston, 2013 [15]; Usher-Smith et al., 2017 [20]; Katusiime et al., 2016 [21]). While, to our knowledge, this is the first attempt at completing a formal concept analysis of the patient experience, Wolf and colleagues [3] published a study based on "a need to determine the extent to which clear and formal definitions exist, have common overarching themes, and/or have unique, but important constructs that should be considered more widely" (p.7). This study examined 18 sources including published articles and organizational websites to identify the main elements and themes in existing theoretical definitions of the patient experience. This study [3] restricted to a 14-year time limited (2000 to 2014) literature review without rationale, lacked a formal concept analysis, lacked a framework or systematic approach, and included only sources which provided an explicit definition of the patient experience, therefore omitting all operational definitions.

The meaning of patient experience as a concept deserved close examination to identify its defining attributes and inform future research on the topic using both theoretical and

operation definitions as sources. This involved the identification and the analysis of existing definitions, theories, and measures of the patient experience.

Methods

We used Walker and Avant's [22] concept analysis methodology as a systematic approach to distinguish the defining attributes of the patient experience. Walker and Avant's [22] method of concept analysis consists of eight iterative steps: (1) selecting a concept, (2) determining the aims and purpose of analysis, (3) identifying all uses of the concept, (4) determining the defining attributes, (5) constructing a model case, (6) constructing borderline and contrary cases, (7) identifying antecedents and consequences, and, (8) defining empirical referents.

Search Strategy

The search strategy was developed in conjunction with a librarian and included some variation of the terms "patient experience," "patient and family experience," "patient reported experience measure," "patient reported experience measures" and "patient care experience," in the title or abstract. The detailed search strategy for the bibliographic databases (PubMed, MEDLINE, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Cochrane Database of Systematic Reviews, Nursing and Allied Health, EMBASE, and ABI Inform Collection) was verified by two librarians using the Peer Review of Electronic Search Strategies [23].

To identify all relevant studies and limit the risk of publication bias [24], our extensive search strategy included grey literature such as unpublished reports (e.g. dissertations and theses) and organizational websites. The grey literature search conducted using the ABI Inform Collection, Nursing and Allied Health Databases, and ProQuest Dissertations and Theses databases; was limited to reports, dissertations, theses, and working papers. Moreover,

the search engine, Google, was used to seek organization websites and other sources. A modified version of the effort bounded guideline [25], which consists of searching the top 100 webpages served as the strategy for searching Google; the search stopped as nothing was relevant on the three final and consecutive pages. Since there was nothing relevant for three consecutive pages, it was likely that the information would continue to be irrelevant.

Inclusion and Exclusion Criteria

Paley (1996) [26] raised concerns that conceptual clarification cannot be achieved without examining theoretical literature as concepts have different meaning according to the context of different theories, supporting the inclusion of both theoretical and empirical literature. Explicit inclusion criteria restricted the search to studies written in English and French, but not limited to Canadian literature since English and French-speaking countries share terminology. Research studies of all designs and articles such as literature reviews and scholarly commentaries comprised the inclusion criteria.

The full-text of the included articles were then independently reviewed by two reviewers to determine which used the patient experience as an autonomous concept, the main topic of the article, the variable of study, or as the fundamental concept that was defined, described, or developed explicitly. Strictly, the adult population (18 years of age and above) and acute care setting were considered.

Articles, which used the term patient experience in an autonomous, or meaningful way, rather than as a replacement for an active verb, were included. Patient experience may serve as a verb or as a synonym in a sentence versus acting as an autonomous concept. Patient experience can act as a synonym for “encounter” or “undergo,” for example, “patient experiencing surgery” instead of “patients undergoing surgery” or “patient experiencing

harassment” instead of “patient facing harassment.” In these examples, the patient experience was not considered an autonomous concept as it served as a synonym and expressed as a verb.

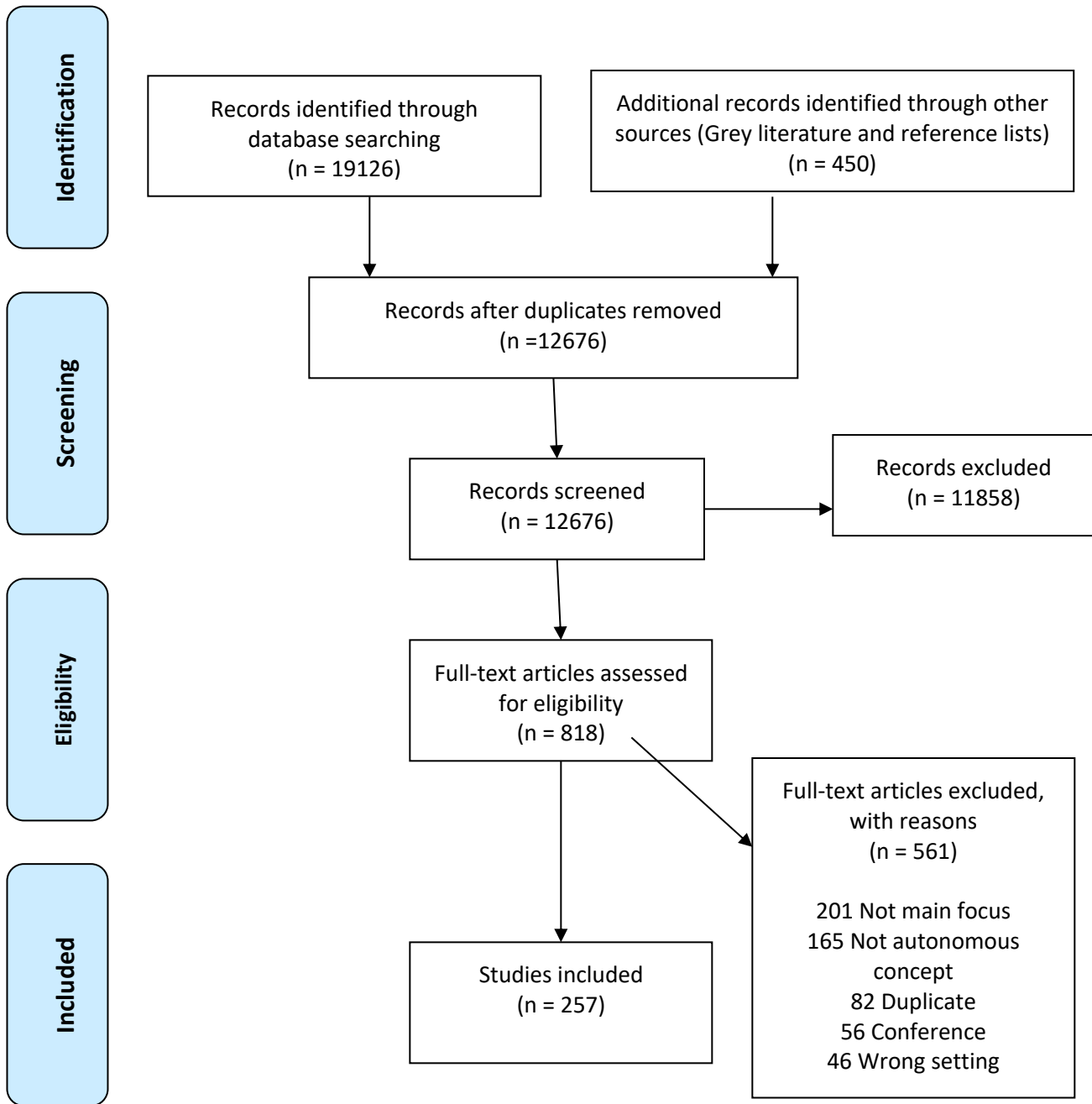
Exclusion criteria consisted of articles that were not in the English or French language and those that did not contain the term "patient experience" within the article. Articles, which did not use the patient experience as an autonomous concept or the main focus, were excluded. Additionally, exclusion criteria comprised of all primary care setting, all paediatric populations (under the age of 18), duplicate articles, and conference proceedings.

Screening Literature

The results from each database were uploaded into reference manager software (Endnote) after duplicates were removed using the Bond University Centre for Research in Evidence-Based Practice- Systematic Review Assistant Deduplication Module (CREBP-SRA-DM) as it was shown to have higher specificity and sensitivity than EndNote [27]. The first search resulted in 19,126 references, which decreased to 12,676 after the de-duplication process. A computer-based reference management software program (Covidence) served for citation screening, abstract review, full-text review, eligibility (study selection) and data export.

Two independent reviewers screened the titles and abstracts (or full text if the abstract was not available) to identify articles that used the term patient experience within the article. Articles proceeded to full-text screening if both independent reviewers were unsure whether to include or exclude the study based on the title and abstract. When disagreements occurred, a discussion occurred until the two reviewers reached consensus and if necessary, a third reviewer was used to resolve any disparities. Search findings were documented using Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Figure 4.1) [28] and the reasons for exclusion of all articles that had the full-text retrieved.

Figure 4. 1 PRISMA Flow Diagram for Included Articles and Organizational Websites



Data Extraction

Walker and Avant’s [22] steps guided the data extraction process performed by one reviewer and independently verified by a second reviewer. The data extraction categories included: author, title, study design, country, patient population, sample size, type of hospital, data collection methodology, data analysis, theoretical definitions of the patient experience,

operational definitions of the patient experience, patient experience instruments used, framework or theory used, related terms, antecedents, and, consequences. Demographic information was also extracted which included patient's marital status; previous hospitalizations; health risk behaviours; ethnicity and race; living situation; income; employment; gender; age; health diagnosis mentioned; readmission; culture and nationality; length of hospital stay; highest level of education achieved; patient's self-reported mental, physical and emotional health rating; and type of healthcare insurance.

In a separate data sheet, extraction included the authors, article titles, instrument names and modifications to the original, and the number of patient experience domains. All theoretical and operational definitions were disassembled into features and sub-features of the patient experience. Instruments were considered as operational definitions and theoretical definitions were extracted and disassembled in the same manner. The data extraction sheets were piloted and revised on a few occasions for the first twenty articles. Endnote was used to keep track of references.

Data Analysis

The data synthesis was conducted, and narrative review of the findings is provided. To ensure an unbiased interpretation of the data, one reviewer independently extracted, and a second reviewer independently verified the identification of attributes, antecedents, and consequences. Any attributes, antecedents, and consequences not noted by one reviewer were discussed between the two reviewers and added if appropriate. The reviewers independently reread the articles until data saturation occurred for the attributes, antecedents, and consequences.

The theoretical definitions were analyzed and separated into features and combined with the features from the operational definitions (e.g. instruments) then further categorized

into attributes. The process of assessing, combining, further analyzing, organizing, and clustering the features and sub-features into attributes and themes required numerous reiterations.

Results

Characteristics of Included Studies

The first database search resulted in 19,126 articles, which decreased to 12,676 after the removal of duplicates. Two independent reviewers screened the titles and abstracts of the 12,676 articles for eligibility, resulting in 818 full-text articles. After assessing the full-text of the 818 articles, we excluded 201 for not including the patient experience as the main focus, 165 for not referring to the patient experience as an autonomous concept, 82 duplicates, 56 conference proceeding, and 46 for the wrong setting. This process resulted in 257 included articles and organizational websites. Search findings were documented using a PRISMA flow diagram and are presented in Figure 4.1.

Countries of Study Origin

The 257 articles and organizational websites used for this concept analysis originated from 26 countries (The United States, Canada, Wales, England, Ireland, Scotland, Norway, Faroe Islands, Poland, Sweden, Denmark, Netherland, Switzerland, Belgium, Germany, France, Italy, Spain, China, Jordan, Japan, Nepal, Australia, New Zealand, Ethiopia, and South Africa) that were organized into five continents: North America, Europe, Asia, Australia and Africa. The five continents and their relevant attributes are summarized in Table 4.4.

Study Settings

The 257 included articles also represent nine acute-care settings: medicine-surgery, oncology, intensive care unit (ICU), emergency department (ED), gynaecology/ obstetrics, specialized care units (e.g. cardiology), rehabilitation and geriatrics, psychiatry, and, all inpatient units (studies where inclusion criteria simply stated all units without specifying). Due to the small sample size of some of the settings including rehabilitation and geriatrics, and, psychiatry, the settings were grouped into inpatient units (medicine-surgery, gynecology/ obstetrics, specialized care units, rehabilitation and geriatrics, and, psychiatry) and critical care (ICU and ED). Articles which stated, “all inpatient units included” (N= 79; 31%) as their setting, were not included in the analysis of the settings as it is unknown which setting their results represented the most. Moreover, we excluded articles that did not have a setting (N=41; 16%) from the analysis of the settings. Table 4.5 provides a summary of the acute care units and their relevant patient experience attributes.

Study Designs

Study designs included cross-sectional designs, exploratory, descriptive, ethnography, secondary analysis, literature review, randomized control trials, prospective, retrospective, systematic reviews, longitudinal cohort, phenomenology, observational, qualitative content analysis, case-control, grounded theory, and mixed study designs. Completed and published studies replaced study protocols. We included only one protocol [29] because, to our knowledge, the study remained incomplete. Two librarians aided in the search for the completed article and efforts to contact the authors were unsuccessful. The patient population consisted of adults (18 years of age and older) in the acute care setting.

Theoretical Definitions

Of the 257 included articles, 22 explicitly defined the patient experience (Table 4.1) and 14 of those contained a unique definition. Of the twenty-two articles, six authors [3, 30-34] used The Beryl Institute’s definition of the patient experience which is “the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care” [30]. The definitions of the patient experience by the AHRQ [35, 36], Robinson (2010) [33, 37], and by The Cleveland Clinic [34, 38] were cited twice. Nine (41%) of the definitions were from published studies [3, 6, 29, 33, 34, 39-42], while thirteen (60%) of the twenty-two were from unpublished articles [30-32, 35-38, 43-48].

Table 4. 1 Theoretical Definitions Chart

Author	Definition
Agency for Healthcare Research and Quality (2017)[35] This definition was also cited and acknowledged by: <ul style="list-style-type: none"> • Heath(2017)[49] 	"Patient experience encompasses the range of interactions that patients have with the health care system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities. As an integral component of health care quality, patient experience includes several aspects of health care delivery that patients value highly when they seek and receive care, such as getting timely appointments, easy access to information, and good communication with health care providers."
Association for Patient Experience (2016)[43]	“What is patient experience? It is providing the best clinical care and service possible for patients, and it is our collective responsibility. Safety and physical comfort must be included, as well as the patient’s educational, emotional and spiritual needs. This includes everything from making sure questions are answered, to reducing wait times, to getting him or her home safely.”
The Beryl Institute (2010)[30] This definition was also cited and acknowledged by: <ul style="list-style-type: none"> • Canadian Foundation for Healthcare Improvement (2018)[31] • Jha,Frye & Schlimgen (2017)[33] • Modic et al. (2014)[34] 	The Beryl Institute defines patient experience as “the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care”.

<ul style="list-style-type: none"> • Siemens Healthineers (2018)[32] • Wolf et al. (2014) [3] 	
<p>Cleveland Clinic (2018)[38]</p> <p>This definition is also cited and acknowledged by:</p> <ul style="list-style-type: none"> • Modic et al. (2014)[34] 	<p>“Cleveland Clinic defines our patient experience as putting "Patients First." Patients First is...Safe Care, High Value Care, High Quality Care, Patient Satisfaction”. Cleveland Clinic defines putting patient’s first as “care that addresses every aspect of patients’ encounters, including their physical comfort, as well as their educational, emotional and spiritual needs.”[50]</p>
<p>De Regge et al. (2017)[39]</p>	<p>“Patient experience is a measure of patient-centeredness, one of the six health care quality aims proposed by the Institute of Medicine (IOM). While patient satisfaction surveys give ratings of satisfaction with care, patient experience surveys elicit reports from patients on what they did or did not experience in their interactions with health care providers”.</p>
<p>Edwards, Duff & Walker (2014) [51]</p>	<p>“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.”</p> <p>...</p> <p>“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.”</p> <p>...</p> <p>“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).</p> <p>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).”</p>
<p>Fooks et al. (2015)[40]</p>	<p>“Patient experience is how patients perceive and experience their care (hopefully patient-centered)”.</p>
<p>Hagerty et al. (2017)[41]</p>	<p>“Patients’ experiences are defined as their perceptions of phenomena for which they are the best or only sources of information, such as personal comfort or effectiveness of discharge planning.”</p>
<p>Kemp et al. (2016)[42]</p>	<p>Uses Wolf’s [52]definition:</p>

	“Experience encompasses more than a sense of satisfaction and ‘is defined in all that is perceived, understood and remembered’. Patient experience is ‘about ensuring the best in quality, safety and service outcomes’. It can assess aspects of PCC such as the inclusion of the patient in care decisions, as well as issues such as patient understanding of their condition/ treatment and discharge instructions”.
Lawrence General Hospital (2018)[44]	“This team has worked with staff, physicians, patients, and leaders to develop a definition of the Lawrence General Patient Experience: We promote healing through the sum of all interactions shaped by compassionate, respectful and attentive care for our patients and their families”.
Modic et al. (2014)[34]	Uses the Cleveland Clinic, the Beryl Institute and the Press Ganey (from CEO Patrick Ryan’s) definitions. “According to Press Ganey CEO Patrick Ryan, the patient experience is “not about happiness. It’s about patients being respected, being communicated with and having their care coordinated in such a way that they can get the best possible clinical outcome for whatever their circumstances are.”
Newell & Jordan (2015)[29]	“Patients are being surveyed on their healthcare experience across interpersonal areas such as being provided the opportunity by their health professional to ask questions, the level of involvement in their own care and whether they were shown courtesy, treated with respect and listened to carefully by their health professional”.
Robinson (2010)[37] This definition was also cited and acknowledged by: • Jha, Frye & Schlimgen (2017)[33]	“Engaged healthcare is better healthcare, for everyone. And that’s the best definition of the patient experience.”
Rudolph (2016)[53]	“To this end, we define the patient experience as ‘everything we say and do that affects our patients’ thoughts, feelings, and well-being’.”
Schauer (2015)[54]	“Patient experience is defined as delivering ‘safe, quality, high-value care’ and notes that everything a physician does in front of the patient influences their experience’.”
Solomon (2017)[47]	“Customer service’s analog in healthcare—variously called patient experience, patient satisfaction, PX, etc.—comes down to providing service in an environment where the goals of the customer can be complex, and where appropriate service to the customer may take the provider from the typical customer service approach of striving to provide immediate customer gratification”.
William Osler Health System (2018)[48]	“Patient experience is patient satisfaction, safety, access to care, quality of care that is consistently delivered with compassion.”

Operational Definitions

Of the 257 included articles, 242 provided an operational definition of the patient experience. Table 4.6 provides a complete list of patient experience instruments. Only three per cent (n=8) provided both a theoretical and operational definition of the patient experience

[33, 35, 36, 38, 39, 41, 42, 51]. The operational definition of the patient experience ranged widely from instruments using three (e.g. Three- Item Care Transition Measure [55, 56]) to 189 questions (e.g. The Fifth National Health Service Survey [57]) to define the patient experience.

A total of 104 unique instruments measured the patient experience: 99 questionnaires, three frameworks, one reporting system and one toolkit. The 99 questionnaires separate into 64 titled and 35 unnamed questionnaires. In addition to the listed instruments, there were numerous modified versions of the Hospital Consumer Assessment of Healthcare Providers and Systems [58], the National Cancer Patient Experience Survey[59], the Perceived Hospital Environment Quality Indicators instrument [60], and the Picker Patient Experience Questionnaire [61].

Attributes Analysis

The list of features (Table 4.2) were combined into synonyms, further analyzed, organized and clustered into attributes. Twenty key defining attributes for the patient experience concept were identified: (1) communication; (2) respect for patients; (3) information and education; (4) patient-centered care; (5) discharge from hospital; (6) hospital environment; (7) comfort and pain; (8) professionalism and trust; (9) clinical care and staff competency; (10) access to care; (11) global ratings; (12) medication; (13) transitions and continuity (14) emotional dimension; (15) outcomes; (16) hospital processes; (17) safety and security; (18) interdisciplinary team; (19) social dimension; and, (20) patient dependent features. The twenty attributes are comprised of 67 features. Table 4.3 provides a summary of the complete list of attributes and features with definitions and illustrative quotes.

The Most Frequent Attributes

‘Communication’ is the most frequent attribute (N=163; 63%) appearing across all continents and settings, followed by ‘respect for patients’ (N=125; 49%), ‘information and education’ (N= 124; 48%); and ‘patient-centered care’ (N= 118; 46%).

The Least Frequent Attributes

The least frequent attributes are ‘patient dependent features’ (N= 13; 5%), ‘social dimensions’ (N= 27; 11%), ‘interdisciplinary team’ (N= 28; 11%), and ‘safety and security’ (N= 41; 16%). The complete list of attributes and features is presented in Table 4.3.

Table 4. 2 Complete List of Features

Feature (N=67)	N	% of Attribute	% of Total
Respect and Dignity	112	90%	44%
Pain Management	102	90%	40%
Discharge Process	99	89%	39%
Doctor Communication	91	56%	35%
Nursing Communication	86	53%	33%
Tailored Information Provision	85	69%	33%
Medication Management	84	100%	33%
Patient as Active Participant	75	64%	29%
Involvement of Friends and Family	69	59%	27%
Overall Hospital Rating	66	73%	26%
Communication by All Staff	66	41%	26%
Care Coordination	64	70%	25%
Staff Responsiveness	64	63%	25%
Overall Care from Received Nurses	61	59%	24%
Emotional Support	58	91%	23%
Transition of Care between Sectors	58	91%	23%
Hospital Cleanliness	57	52%	22%
Overall Care from Doctors	51	59%	20%
Hospital Noise	51	46%	20%
Overall Hospital Environment and Aesthetics	50	46%	20%
Waiting Time and Delays	47	52%	18%
Availability of Staff to Answer Patient’s Questions	44	27%	17%
Trust and Confidence in Healthcare Professionals	43	42%	17%

Consistency and Accuracy of Information	39	31%	15%
Overall Satisfaction	38	78%	15%
Willingness to Recommend Hospital to Friends and Family	38	42%	15%
Patient Safety	37	90%	14%
Privacy	37	30%	14%
Handling Patient's Complaints and Feedback	33	77%	13%
Interdisciplinary Relationships	28	100%	11%
Physical Comfort	27	24%	11%
Information About Tests and Procedures	26	21%	10%
Discharge Education About "Danger Signals"	25	23%	10%
Accessing Care	24	26%	9%
Hospital Food	23	21%	9%
Personal Support	22	22%	9%
Social Aspects	21	78%	8%
Outcomes of Care	21	43%	8%
Tests and Procedures	21	21%	8%
Patient Preferences	21	18%	8%
Nursing Competence	20	20%	8%
Overall Experience	19	21%	7%
Educating Patients and Family	19	15%	7%
Patient's Comprehension of Information	18	15%	7%
Nursing Staffing Levels	15	35%	6%
Supportive Interventions and Resources	15	15%	6%
Doctor's Competence	14	14%	6%
Individualized Care	14	12%	6%
Hospital Equipment	13	12%	5%
Written Information	13	11%	5%
Overall Care from all Other Healthcare Professionals	12	12%	5%
Options for Care	12	11%	5%
Patient Preparation	12	10%	5%
Emotional Status	11	85%	4%
Transition of Care within the Hospital	10	16%	4%
Cost of Care	8	9%	3%
Patient Readiness for Discharge	8	8%	3%
Physical Abilities	7	54%	3%
Hospital Living Arrangements	7	26%	3%
Empathy Towards Patient	7	11%	3%
Discharge Education About Medications	7	6%	3%
Cognitive Capacity	6	46%	2%
Equality	6	5%	2%
Existential Aspects	5	39%	2%
Hospital Safety Processes	5	12%	2%
Consistency of Staff	3	3%	1%
Discrimination	3	2%	1%

Table 4. 3 Summary of Attributes and Features with Definitions and Illustrative Quotes

Attribute (N=257) 100%					
Attribute Summary					
Features	N	%	Definition of Feature	References	Illustrative Quote
Communication (N=163) 63%					
Verbal and non-verbal communication between healthcare providers and patients.					
Doctor Communication	N= 91	56%	Doctor's "communication style and format (e.g. over telephone or in person); skills and characteristics of health care professional; body language (which can convey different information from that spoke); two-way communication... Listening and paying attention to the patient". [1]	[1-91]	"When you had important questions to ask the doctor, did you get answers that you could understand?" [8]
Nursing Communication	N=86	53%	Exchange of information between patients and nurses.	[1-3, 5-8, 10-21, 23, 24, 26, 28-33, 35-39, 42-45, 47-50, 52-56, 58-63, 65-75, 77-79, 81, 84-86, 88, 91-105]	"Nurses always listened carefully to you Nurses always explained things in a way you could understand" [30]
Communication by All Staff	N= 66	41%	Level of communication between hospital staff and patient including staff introducing themselves and not withholding information from the patient.	[1, 3, 7, 17, 22, 34, 35, 42, 54, 58, 60, 62, 64, 73, 77, 83, 85, 87, 88, 91, 99, 106-151]	Care team explained what was being done; felt that care team really listened. Care team introduced themselves when first met patient." [111]
Availability of Staff to Answer Patient's Questions	N= 44	27%	The opportunity and amount of time staff spent interacting and communicating with patients. "Enabling questions and providing answers". [1]	[5, 16, 21, 22, 27, 53, 54, 60, 70, 71, 75, 79, 82, 85, 88, 89, 92, 99, 114, 117-119, 124, 125, 133, 136, 137, 143, 144, 152-166]	"How do you rate the availability of the medical doctors who took care of you?" [155]

<p align="center">Respect for Patients (N=125) 49%</p> <p align="center">Healthcare providers always treating patients and family members with respect and dignity, which includes providing patients with privacy and not discriminating.</p>					
Respect and Dignity	N= 112	90%	Patients treated with respect and matters related to dignity by staff.	[1, 3, 5, 7-9, 20, 22, 25-28, 30, 35-38, 40-42, 44, 45, 48, 49, 53, 55, 56, 58-60, 62, 67-72, 74, 75, 78, 79, 81-83, 88, 90, 92-95, 99, 103, 106, 108, 110-115, 118, 119, 121, 123-126, 129, 130, 134, 137, 138, 141-143, 152, 153, 156, 157, 160-163, 167-196]	“Always treated with respect and dignity by staff.”[152]
Privacy	N= 37	30%	Patients provided with privacy during discussions, treatments and exams.	[7, 8, 18, 23, 27, 35, 37, 38, 49, 54, 58, 60, 66, 70, 79, 84, 85, 92, 99, 108, 112, 119, 124, 126, 137, 143, 148, 149, 162, 163, 176, 183, 186, 194, 197-199]	“My privacy was respected during examinations, treatment and care.” [7]
Equality	N= 6	5%	All patients treated with equality by staff.	[3, 59, 92, 150, 178, 181]	“Nurses favoured some patients over others.” [92]
Discrimination	N= 3	2%	Discrimination towards patients by staff.	[124, 172, 188]	“Sometimes groups of people are treated in an unjust and unfavourable manner based on prejudice (discrimination)...During your hospital stay, did you experience any discrimination due to your ...”[172]
<p align="center">Information and Education (N=124) 48%</p> <p align="center">Consistent, accurate, and tailored information provision and education to patients and family on all aspects of diagnoses, tests, procedures, and care.</p>					
Tailored Information Provision	N= 85	69%	Various methods of timely and adequate information provided.	[1, 3, 5, 7, 8, 16, 18, 21, 22, 24, 26, 27, 36, 37, 40, 49, 53, 54, 58-60, 62, 64, 67, 68, 71, 74, 77, 81, 85, 86, 89, 91, 106, 108-114, 119, 120, 122, 123, 125-129,	“Did you get the information you needed during your admission? (e.g. about your illness, examinations, treatments and side effects)”[40]

				131, 135-137, 140-143, 145, 146, 151, 156, 157, 167, 171, 173, 176, 179, 180, 182, 184-186, 188-190, 195, 198, 200-206]	
Consistency and Accuracy of Information	N= 39	31%	Consistency in information provided to patient by staff.	[5, 7, 8, 20-22, 26, 35, 37, 38, 40, 42, 49, 53, 54, 60, 67, 69, 71, 72, 77-79, 85, 92, 109, 110, 114, 118, 119, 126, 129, 137, 168, 171, 183, 188, 198, 207]	“Hospital staff did not contradict each other.” [7]
Information About Tests and Procedures	N= 26	21%	Patients were provided with sufficient information regarding tests and procedures.	[16, 21, 27, 46, 54, 58, 60, 62, 71, 76, 79, 82, 84, 85, 87, 88, 109, 118, 119, 127-129, 137, 151, 176, 186]	““What would be done during operation explained...anesthetic procedure explained completely... risks and benefits of operation explained...told what to expect to feel after operation;” [37]
Educating Patients and Family	N= 19	15%	Patient and family education regarding disease and infection control provide.	[1, 24, 53, 54, 58, 85, 106, 129, 144, 151, 165, 179, 180, 182, 184, 185, 190, 195, 208]	“Have you been offered education about your illness and its treatment in connection with your disease?” [129]
Patient’s Comprehension of Information	N= 18	15%	Patient’s understanding of information received from staff.	[7, 16, 28, 30, 32, 62, 69, 71, 72, 93, 107, 136, 143, 156, 170, 178, 209, 210]	“You had a good understanding of the things you were responsible for in managing your health. You clearly understood the purpose for taking each of your medications” [30]
Written Information	N= 13	11%	Providing patients with written information about their diagnosis, tests, procedures, results and other components of their healthcare.	[4, 32, 62, 68, 79, 81, 87, 134, 150, 152, 154, 158, 211]	“When you were told you had cancer, were you given written information about the type of cancer you had?” [87]
Patient Preparation	N= 12	10%	Level of preparation by staff patient’s received prior to care provision.	[7, 27, 54, 60, 78, 79, 82, 85, 149, 156, 170, 206]	“Level of preparation for procedure from surgeons... level of preparation for procedure from nurses;” [156]
Patient- Centered Care (N=118) 46%					

Provision of individualized and preferred patient care which includes patient and family as active participants.					
Patient as Active Participant	N= 75	64%	“Reflects the role of patients as potential active participants in their health care, co-creators and co-managers of their health and use of services; responsible for self-care, participators in health care, shared decision-makers, self-managers, risk managers and life-style managers.” [1]	[1, 3-5, 7, 8, 18, 20, 22, 34, 37, 38, 47, 49, 53-55, 58-60, 62, 66-75, 78, 79, 81, 82, 85, 106, 108, 115, 119, 120, 123-126, 129, 130, 137, 141-144, 151, 157, 158, 163, 168, 171, 174, 176, 178, 180, 181, 183, 186, 197, 203, 206, 208, 211-216]	“Were you involved as much as you wanted to be in decisions made about your care and treatment?” [8]
Involvement of Friends and Family	N= 69	59%	“Any aspect related to family members’ (or other caregiver) experience with the hospital in conjunction with the patient’s stay”. [149] Includes involving friends and family in decision-making and patient care.	[4, 5, 16, 20-22, 27, 37, 53-56, 58-60, 62, 67-72, 77-79, 81-85, 93, 106, 109, 111, 112, 114, 115, 118, 119, 124, 126-129, 133, 136, 137, 144, 148, 149, 156, 163, 167, 178-182, 184-186, 189, 190, 195, 200, 201, 208, 211, 217]	“Involvement of family and friends: family didn't get opportunity to talk to doctor; family not given enough information about condition; family not given information needed to help recovery”. [22]
Patient Preferences	N= 21	18%	Patient preferences regarding care respected and taken into consideration.	[26, 28, 30, 53, 59, 60, 69, 70, 72, 89, 93, 114, 117, 137, 143, 167, 179, 186, 188, 189, 211]	“Staff took your preferences and those of your family into account in deciding what your health care needs would be” [28]
Individualized Care	N= 14	12%	Providing unique care adjusted to the patient situation.	[1, 3, 58-60, 74, 103, 111, 136, 142, 157, 208, 211, 218]	“Do you consider that your treatment has been adjusted to your situation?” [157]
Options for Care	N= 12	11%	Providing patients with options to choose from for various aspects of care.	[8, 21, 38, 60, 79, 86, 114, 124, 131, 134, 171, 202]	“Freedom to choose health care provider” [124].
<p>Comfort and Pain (N= 114) 44% Providing effective pain management and interventions to ease patient’s physical discomforts.</p>					

Pain Management	N= 102	90%	“Effective management of the patient’s pain”. [149]	[5-15, 17, 19, 21-23, 26-28, 30, 31, 33, 36-38, 42-45, 47-55, 58, 60-63, 66-68, 70, 77, 79, 81, 83, 85, 88, 94-97, 108, 109, 111, 114, 116, 119-121, 123, 128, 137, 138, 141-146, 149, 151, 152, 155, 158, 168, 170, 180, 182, 183, 186, 188, 193, 197, 202, 205, 206, 209, 219-227]	“Do you think the hospital staff did everything they could to help control your pain?” [8]
Physical Comfort	N= 27	24%	Patient’s level of physical comfort during hospital stay (e.g. treatment of shortness o breath).	[2, 3, 5, 40, 42, 44, 58-60, 70, 81, 106, 115, 119, 143, 165, 167, 170, 173, 179, 180, 182, 184-186, 188, 209]	“One of the most immediately disturbing aspects of illness is the physical discomfort and disability it brings. Physical care that comforts patients, especially when they are acutely ill, is one of the most elemental services that caregivers can provide, from the patients' perspective.” [132]
<p>Discharge from Hospital (N=111) 43% Ensuring proper patient preparation and readiness for discharge through coordination and education.</p>					
Discharge Process	N= 99	89%	Procedures related to discharge decisions, adequate communication and information provision related to care at home.	[4, 6-8, 10-22, 24, 26-31, 33, 35, 40, 42, 43, 47, 48, 50-52, 57-62, 65, 66, 68-74, 77, 79-82, 86, 88, 93, 97, 109, 116, 118, 120, 121, 127-129, 135, 137, 140-144, 147, 149, 160, 162, 165, 180, 186-188, 190, 195, 198, 200-202, 204, 206, 209, 211, 212, 224, 228-232]	“Were you given clear written information about what you should or should not do after leaving hospital?” [73]
Discharge Education About “Danger Signals”	N= 25	23%	Information provision related to signs and symptoms patients should watch for and seek medical care if experiencing.	[5, 8, 20, 22, 28, 30, 38, 42, 48, 53-55, 60, 62, 68, 70, 77, 78, 81, 84, 85, 88, 93, 118, 171]	“Did a member of staff tell you about any danger signals you should watch for after you went home?” [38]

Patient Readiness for Discharge	N= 8	8%	Patient's feeling of readiness for discharge and readmission rates. Notifying patient of discharge in a timely manner.	[4, 7, 40, 60, 77, 94, 135, 207]	"The extent to which you felt ready to be discharged" [135]
Discharge Education About Medications	N= 7	6%	Information provisions related to medicines patients are prescribed to take at home.	[27, 40, 70, 71, 89, 93, 160]	"I received adequate information on further treatment after my dismissal from the hospital the use of medicines or tools, etc.)." [7]
Hospital Environment (N= 110) 43% The interior and exterior hospital facilities, services and environment.					
Hospital Cleanliness	N= 57	52%	Perceived cleanliness of the hospital environment including the patient rooms and washrooms.	[2, 6, 8, 10-15, 17, 21, 23, 24, 27-31, 33, 38, 41-45, 48, 49, 54, 57, 60-62, 65, 66, 68, 70, 78, 81, 85, 106, 121, 124, 141-143, 149, 162, 168, 169, 171, 183, 188, 202, 224, 232-234]	"In your opinion, how clean was the hospital room or ward that you were in?" [8]
Hospital Noise	N= 51	46%	The level of noise in and outside the patient's room.	[6, 8, 10-15, 17, 23, 24, 27-31, 33, 37, 38, 41-45, 48, 49, 54, 57, 60-62, 65, 66, 68, 70, 78, 81, 85, 94, 100, 103, 111, 141, 143, 145, 146, 149, 161, 235-237]	"Were you ever bothered by noise at night from hospital staff?" [8]
Overall Hospital Environment and Aesthetics	N= 50	46%	"Physical appearance/environment of the hospital" [149] and hospital culture includes temperature and odour.	[1, 16, 19, 21, 23, 26, 27, 40, 41, 49, 50, 54, 58, 60, 70, 85, 95, 106, 109, 116, 120, 122-124, 131, 134, 141-143, 148, 149, 175, 176, 180, 186, 191, 197, 199-202, 206, 227, 229, 235, 237-241]	"Physical appearance/environment of the hospital (e.g. aesthetics, temperature, layout)" [149]
Hospital Food	N= 23	21%	"Patient's food ordering and delivery processes, as well as food quality"	[8, 21, 23, 27, 38, 54, 60, 69, 72, 78, 85, 86, 116, 134, 140, 143,	"How would you rate the hospital food?" [8]

			[149], availability and fasting process while in hospital.	149, 163, 186, 204, 224, 242, 243]	
Hospital Equipment	N= 13	12%	Availability of non-medical and medical equipment and supplies.	[16, 58, 60, 64, 77, 122, 124, 127, 149, 161, 163, 186, 199]	“Adequate equipment” [124]
<p>Professionalism and Trust (N= 103) 40% Hospital staff’s professionalism towards patients and patient’s trust and rating of overall care received.</p>					
Overall Care Received from Nurses	N= 61	59%	The care which nurses provide to patients	[3, 4, 21, 22, 24, 35, 37, 40, 46, 51, 58-60, 64, 73, 74, 76, 77, 92, 96, 103-105, 109, 112, 121-123, 127-129, 137, 141, 143, 149, 155, 156, 159, 161, 165, 168, 174, 176, 178, 181, 183, 186, 197, 200-202, 207, 224, 227, 232, 234, 242, 244-247]	“The genuine caring and concern shown to you by the nurses.” [96]
Overall Care Received from Doctors	N= 51	50%	“Matters related to function and interaction specifically with” [149] doctors. The care doctors provide to patients including doctor –	[1, 3, 16, 21, 22, 24, 25, 27, 34, 35, 37, 38, 58-60, 71, 76, 77, 96, 109, 114, 119, 121-124, 127, 128, 134, 137, 141, 149, 156, 159, 168, 173, 176, 177, 183, 186, 200-202, 206, 207, 224, 227, 232, 234, 242, 246]	“Quality of care received- doctors”[121]
Trust and Confidence in Healthcare Professionals	N= 43	42%	The level of trust patients has in healthcare professionals.	[1, 16, 18, 21-23, 25, 32, 35, 37-39, 46, 49, 55, 58, 60, 67, 69, 72, 73, 77-79, 82, 99, 110, 112, 114, 118, 126, 137, 138, 142, 143, 148, 160, 174, 175, 178, 181, 192, 198]	“Did you have confidence and trust in the doctors treating you?... Did you have confidence and trust in the ward nurses treating you?” [73]
Overall Care from all Other Healthcare Professionals	N= 12	12%	The care other healthcare professionals provide to patients.	[24, 37, 60, 87, 89, 117, 121, 140, 159, 206, 207, 248]	“How well do you think the pharmacist listened

					to your questions or what you had to say about your medicines?" [117].
<p>Clinical Care & Staff Competency (N= 101) 39% Patient's perceived healthcare professional's competence, and the clinical care received.</p>					
Staff Responsiveness	N= 64	63%	"Availability, willingness, timeliness, and attitude of staff to respond to patient needs". [149]	[1, 6, 9-15, 17, 19, 22, 24, 27, 28, 30, 31, 33, 35, 37, 41-44, 48-50, 52, 54, 57, 58, 60-62, 65-68, 70, 74, 81, 85, 86, 92, 94, 97, 105, 111, 112, 118, 143, 144, 149, 151, 154, 155, 178, 181, 188, 194, 205, 206, 224, 249]	"After you pressed the call button, how often did you get help as soon as you wanted it?"[250].
Personal Support	N= 22	22%	Support for self-care and activities of daily living including toileting help.	[18, 22, 36, 53, 54, 60, 62, 68, 69, 72, 85, 86, 141, 161, 176, 189, 190, 194, 195, 202, 206, 244]	"Did you get enough help that you needed from the staff (e.g. eating meals, going to the toilet, and moving from/to bed)?" [176]
Tests and Procedures	N= 21	21%	Frequency, timeliness, comfort, accuracy and quality of tests, examinations and procedures.	[27, 37, 47, 58, 60, 62, 68, 71, 77-79, 81, 88, 123, 152, 156, 162, 193, 202, 206, 227]	"During this emergency room visit, did you have a blood test, x-ray, or any other test?" [88]
Nursing Competence	N= 20	20%	Perceived nurses' technical skills and knowledge about the patient's condition and treatment.	[1, 3, 16, 21, 27, 58, 60, 69, 72, 74, 76, 77, 92, 96, 112, 123, 129, 141, 143, 193]	"Nurses knew what to do without relying on doctors" [92].
Supportive Interventions and Resources	N= 15	15%	Staff providing patients with supportive interventions and awareness of patient's needs.	[2, 21, 60, 69, 72, 77-79, 110, 113, 129, 134, 140, 154, 203]	"Did hospital staff do everything possible to control the side effects of chemotherapy? Did hospital staff do everything possible to control the side effects of radiotherapy?" [113].
Doctor's Competence	N= 14	14%	Perceived doctor's skills, qualifications, knowledge, treatment and all aspects of the patient's health and condition.	[3, 16, 21, 27, 58, 60, 69, 72, 76, 78, 96, 123, 129, 141]	"The doctors seemed to be qualified" [27]

Consistency of Staff	N= 3	3%	Consistency in the healthcare personnel who are caring for the patient during their stay.	[16, 21, 60]	“One doctor responsible; Same group of nurses;” [16]
<p>Access to Care (N= 91) 35% Patient’s access to care including hospital processes, care coordination, delays and cost of care.</p>					
Care Coordination	N= 64	70%	How organized and well planned processes, clinical care, ancillary and support services are at the hospital.	[1, 3, 5, 8, 9, 21, 22, 26, 27, 38, 40, 42, 53-55, 58-60, 62, 64, 68, 77-79, 81, 96, 106, 107, 109, 110, 113-115, 118-122, 129, 137, 139, 142, 147, 148, 167, 168, 171, 176, 179, 180, 182, 184, 185, 189, 190, 195, 200-203, 206, 217, 246, 251]	“. How well organized was your care? (all of your tests, treatments and visits from different healthcare providers)” [3]
Waiting Time and Delays	N= 47	52%	The amounts of time patients spend waiting for a request or service.	[3, 8, 9, 16, 18, 22, 27, 36, 38, 42, 54, 55, 60, 62, 68-70, 72, 77-79, 81, 86, 88, 91, 99, 110, 112, 116, 118, 121, 122, 124, 137, 141, 155, 162, 165, 171, 175, 176, 186, 192, 200-202, 251]	“Length of time before being examined by a doctor (A&E admission) Length of time before being admitted to a bed on a ward (A&E admission) Perception of length of time to get to a bed on a ward (A&E admission) Length of time on the waiting list before admission (plan admission)” [54].
Accessing Care	N= 24	26%	Ease of hospital access in terms of travel, accessibility and organizational processes.	[1, 9, 26, 27, 54, 59, 60, 85, 88, 106, 110, 113, 122, 124, 129, 136, 137, 141, 143, 152, 166, 167, 180, 189]	“Access- Patients want access to care and they are frustrated by the barriers they often encounter-whether because of telephone triage or voice mail systems; scheduling difficulties; zealous "gatekeepers"; or restrictions imposed by managed care or insurance coverage.” [252]

Cost of Care	N= 8	9%	Financial burden of healthcare related expenditures such as parking and receiving information about financial help, benefits, and resources.	[60, 77, 79, 82, 86, 137, 175, 207]	“Have you been offered physical training in connection with your disease?” [129]
<p>Global Ratings (N= 90) 35% Patient’s overall rating of the hospital and the willingness to recommend the hospital to their friends and family.</p>					
Overall Hospital Rating	N= 66	73%	On a scale of 0 to 10, where 0 is the worse health care possible, and 10 is the best health care possible, what number the patient would assign to the care they received (usually in the last 6 months).	[3, 9, 11, 14, 15, 19, 20, 24, 27, 28, 30, 31, 33, 35, 40, 41, 43, 44, 48, 50-54, 57-63, 65, 66, 68-70, 72, 73, 78, 80, 81, 84, 85, 96, 97, 100, 104, 110, 116, 150, 153, 171, 176, 179, 183, 185, 190, 191, 195, 205, 210, 219, 224, 225, 237, 253]	“Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?” [62]
Willingness to Recommend Hospital to Friends and Family	N= 38	42%	Whether or not the patient would refer the hospital to their friends and family.	[11, 12, 15, 22, 28, 30, 33, 35, 41, 43, 45, 48, 52, 57, 60-62, 66, 68, 81, 88, 97, 109, 119, 121, 122, 143, 169, 170, 172, 179, 181, 190, 225, 234, 237, 246, 254]	“Would you recommend this hospital to your friends and family?” [68]
Overall Experience	N= 19	21%	The patient assigns a number on a scale (usually 0 to 10, where 0 is the worse health care experience, and 10 is the best health care experience) to rate their complete healthcare “experience”.	[8, 15, 18, 21, 36, 58, 59, 62, 88, 100, 116, 121, 168, 171, 182, 202, 225, 234, 255]	“How would you rate your overall experience?” [255]
<p>Medication (N= 84) 33% Accurate, timely and adequate medication administration and information provision to patients.</p>					

Medication Management	N= 84	100%	Timely and adequate information provision regarding medication.	[2, 5, 6, 8, 10-17, 19, 22, 24, 26-31, 33, 37, 38, 42-45, 47-58, 60-62, 64, 65, 67-70, 72, 77, 78, 81, 82, 88, 89, 93, 95, 97, 109, 114, 116-119, 124, 125, 127-129, 134, 141, 142, 160, 162, 171, 178-181, 187, 206, 224, 242]	“Did a doctor explain the purpose of the medicines you were to take at home in a way you could understand? Did a doctor tell you about medication side effects to watch for when you went home?” [53].
<p>Continuum of Care / Transitions and Continuity (N= 65) 25% Care coordination and transition between inpatient units within the hospital and sectors of the healthcare system.</p>					
Transition of Care between Sectors	N= 58	91%	Patient’s continuity of care from the hospital into the community.	[5, 21, 22, 24, 25, 29, 40, 50, 53, 54, 58, 60, 62, 65, 68, 69, 72, 73, 79, 81, 82, 88, 93, 106, 114, 115, 119, 120, 129, 133, 139, 140, 142, 144, 160, 167, 179, 180, 182, 184, 185, 188, 189, 195, 200, 201, 207, 211, 212, 214, 217, 230, 239-241, 256-258]	“Patients often experience a discontinuity of care as they move back and forth between inpatient, outpatient, and home care settings. They do not understand the institutional and functional boundaries and find it difficult to negotiate the system effectively” [132].
Transition of Care within the Hospital	N= 10	16%	Transition in hospital between units.	[3, 36, 47, 62, 86, 133, 144, 161, 163, 202]	“People with injuries are often moved from one unit or hospital to another during their injury care (e.g., from the Emergency Department to Intensive Care Unit to Trauma Unit). If this happened to you, how well did the moves go?” [3].
<p>Emotional Dimension (N=64) 25% The emotional support healthcare professionals provide patients and the level of empathy they show during interactions.</p>					

Emotional Support	N= 58		Receiving emotional support and treatment for emotional needs by hospital staff.	[1, 3, 5, 20, 22, 37, 53, 54, 58-60, 62, 68, 69, 71, 72, 74, 78, 81, 82, 84-86, 89, 92, 103, 108, 112-115, 118, 119, 125, 129, 136, 137, 141-143, 146, 149, 163, 165, 167, 168, 179, 180, 182, 184-186, 188-190, 195, 216, 249]	“Did the staff give you reassurance and support?”[125]
Empathy Towards Patient	N= 7		Patient’s perception that healthcare providers understand the patient’s situation including how the illness affects them and their responsibilities including social responsibilities.	[36, 110, 111, 157, 173, 181, 203]	“Services understood that I had responsibilities, like my need to look after my family.” [110]
<p>Outcomes (N=49) 19% The successfulness and outcome of care in terms of patient satisfaction and problem resolution/curative.</p>					
Overall Satisfaction	N= 38	78%	Patient’s rating of general satisfaction with received hospital care.	[3, 4, 16, 21, 29, 34, 39, 46, 58-60, 76, 77, 109, 121, 123, 127, 128, 131, 138, 143, 145, 146, 156, 157, 166, 167, 169, 170, 199-201, 206, 219, 225, 236, 246, 259]	“How satisfied are you, all in all, with the nursing and the medical or surgical treatment you received in the hospital?” [60]
Outcomes of Care	N= 21	43%	“Patient outcomes following [receiving healthcare] such as readmission, complications, and successful intervention”. [149]	[21, 54, 60, 62, 64, 68, 76, 77, 81, 85, 94, 141-143, 149, 156, 157, 200, 201, 219, 249]	“How well did the surgery relieve the pain in your affected joint?” [225].
<p>Hospital Processes (N= 43) 17% Adequate nursing staffing levels and hospital processes of handling patient’s complaints and feedback.</p>					

Handling Patient's Complaints and Feedback	N= 33	77%	Staff handling of patient feedback, complaints and concerns.	[3, 5, 21, 24, 27, 46, 48, 53, 54, 58, 60, 82, 85, 86, 100, 109, 110, 112, 127-129, 134, 147, 148, 170, 173, 176, 180, 188, 190, 206, 212, 237]	"Staff are informed about errors that happen, given feedback about changes put into place based on event reports, and discuss ways to prevent errors" [147].
Nursing Staffing Levels	N= 15	35%	"Adequacy of the number, availability, and/or appropriate training" [149] of nurses during the patient's hospital stay.	[22, 48, 60, 69, 72, 79, 86, 126, 137, 142, 147, 149, 163, 174, 237]	"Always/nearly always enough nurses on duty"[80].
<p>Safety and Security (N=41) 16% The hospital processes in place to ensure patient safety and patients perceived level of safety.</p>					
Patient Safety	N= 37	90%	Patients feeling safe at the institution with staff and occurrence of adverse events.	[3, 7, 8, 21, 26, 32, 37, 42, 46, 47, 60, 64, 74, 76, 99, 100, 123, 142, 145, 146, 148, 151, 161, 165, 166, 171, 178, 181, 194, 197, 200, 201, 207, 212, 217, 237, 259]	"Before any treatment, examination or surgery began, my identity was checked by asking for my name, first name and date of birth and my identification band (wristband) was checked" [7].
Hospital Safety Processes	N=5	12%	Staff receive support from management and organization relating to maintaining and addressing patient safety.	[7, 48, 147, 157, 163]	"Have you felt safe at the institution?" [157]
<p>Interdisciplinary Team (N=28) 11% The teamwork and interaction between two or more healthcare professionals.</p>					
Interdisciplinary Relationships	N= 28	100%	"Relationship between two or more hospital employees or other healthcare providers". [149] Includes exchange of information and level of respect between two providers, usually regarding patient's care.	[7, 21, 22, 35, 37, 48, 49, 60, 62, 64, 68, 73, 81, 92, 105, 107, 111, 113, 118, 122, 125, 138, 143, 147, 149, 153, 174, 210]	"How would you rate how well the doctors and nurses worked together?" [153].

<p style="text-align: center;">Social Dimension (N= 27) 11%</p> <p style="text-align: center;">Patient’s personal relationships, social roles, and roommate accommodations while in hospital.</p>					
Social Aspects	N= 21	78%	Patient’s personal relationships with family and friends and carrying out social roles.	[1, 2, 21, 49, 58, 92, 99, 106, 124, 141, 163, 171, 174, 193, 194, 197, 199, 202, 207, 212, 227]	“Not feeling supported by my community of friends and family” [2].
Hospital Living Arrangements	N= 7	26%	Living accommodations including roommates and sharing facilities with the opposite sex.	[23, 27, 38, 121, 123, 194, 242]	"Patient complaints included roommates". [100]
<p style="text-align: center;">Patient Dependent Features (N= 13) 5%</p> <p style="text-align: center;">Patient specific characteristics such as their emotional, physical, and cognitive status, and patient’s values and meaning in life.</p>					
Emotional Status	N= 11	85%	Patient’s emotional responses including level of anxiety and depression during hospital stay.	[1, 2, 4, 60, 131, 132, 145, 146, 160, 170, 209]	“It was upsetting to see what happened to other patients.” [131]
Physical Abilities	N= 7	54%	Patient’s individual aspects of physical abilities such as independence with activities of daily living and exercise abilities.	[2, 4, 60, 145, 146, 203, 225]	“Not being able to carry out tasks associated with daily living” [2].
Cognitive Capacity	N= 6	46%	Patient’s level of recollection and orientation during hospital stay.	[2, 60, 131, 145, 146, 209]	“I have no recollection of being in the intensive care unit” [131].
Existential Aspects	N= 5	39%	Patient’s feelings of value, purpose and meaning in life and self-identity.	[1, 2, 60, 145, 146]	“Concern that my spiritual is not meaningful.” [2]

Proposed Definition of The Patient Experience

“Patient experience is the combination of external and internal hospital processes, patient-centered attributes, patient-staff and staff-staff interactions during all episodes of care.”

To create a new definition, the twenty attributes were organized into four themes: external and internal hospital processes, patient dependent features, hospital staff interactions, and hospital staff and patient interactions. The external and internal hospital processes are comprised of the following attributes: transitions and continuity, hospital environment, access to care, hospital processes, global ratings, and, safety and security. In addition, the hospital living arrangements feature from the social aspects attribute also belongs in this theme. The patient dependent features theme is comprised of the outcomes, social aspects, and, patient dependent features attributes. The hospital staff interactions between each other is comprised of the interdisciplinary team attribute. Lastly, the hospital staff and patient interactions theme is comprised following attributes: communication, respect for patients, information and education, patient-centered care, comfort and pain, discharge from hospital, professionalism and trust, clinical care and staff competency, medication management, and, the emotional dimensions attribute.

Continents and Country Analysis

North America and Europe account for 90% of the data, with Asia representing 5%, Australia 4% and Africa 1% of the results. The attributes were comprehensive as 19 out of the 20 attributes appeared across all of the continents except Africa. North America and Europe collectively represented the vast majority of the data (N=232; 90%), and all twenty attributes were present in both continents. ‘Communication’, ‘respect for patients’, ‘patient-centered

care', 'comfort and pain', 'professionalism and trust', and, 'access to care' attributes appeared across all of the settings and continents.

The United States

In North America, the majority of the articles were from the United States (N=100; 84%). There is more variation at the feature level, but 62 of the 67 features did appear under the United States. The five features not represented in United States literature:

1. 'discrimination' (N=3; 2% of the Respect for Patients attribute);
2. 'options for care' (N=12; 11% of the Patient-Centered Care attribute);
3. 'supportive interventions and resources' (N=15; 15% of the Clinical Care and Staff Competency attribute);
4. 'consistency of staff' (N=3; 3% of the Clinical Care and Staff Competency attribute); and,
5. 'hospital living arrangements' (N=7; 26% of the Social Dimensions attribute).

The Safety and Security Attribute

The 'safety and security' attribute only appeared in literature published from North America and Europe. This attribute was missing in the Asian, Australian and African literature. While 'safety and security' did not appear across all of the continents, it did appear across all of the settings.

Africa, Asia and Australia

Africa, as a continent, only displayed 11 of the 20 attributes; however, Africa was the smallest continent sample (N=2) representing less than 1% of the studies. Asia (N=14) and Australia (N=10) represented only 5% and 4% of the studies, respectively, but nineteen of the twenty attributes were still present in the literature published from these continents.

Table 4. 4 Summary Table of Continents and Relevant Attributes

Continents (N=257)								
Attribute			North America (N=119) 46%	Europe (N= 113) 44%	Asia (N=14) 5%	Australia (N=10) 4%	Africa (N=2) 1%	
	N	%						N (Continent) %
Communication	163	63%	√	√	√	√	√	(5) 100%
Respect for Patients	125	49%	√	√	√	√	√	(5) 100%
Information and Education	124	48%	√	√	√	√		(4) 80%
Patient- Centered Care	118	46%	√	√	√	√	√	(5) 100%
Comfort and Pain	114	44%	√	√	√	√	√	(5) 100%
Discharge from Hospital	111	43%	√	√	√	√	√	(5) 100%
Hospital Environment	110	43%	√	√	√	√	√	(5) 100%
Professionalism and Trust	103	40%	√	√	√	√	√	(5) 100%
Clinical Care & Staff Competency	101	39%	√	√	√	√		(4) 80%
Access to Care	91	35%	√	√	√	√	√	(5) 100%
Global Ratings	90	35%	√	√	√	√	√	(5) 100%
Medication	84	33%	√	√	√	√	√	(5) 100%
Transitions and Continuity	65	25%	√	√	√	√		(4) 80%
Emotional Dimension	64	25%	√	√	√	√		(4) 80%
Outcomes	49	19%	√	√	√	√		(4) 80%
Hospital Processes	43	17%	√	√	√	√		(4) 80%
Safety and Security	41	16%	√	√				(2) 40%
Interdisciplinary Team	28	11%	√	√	√	√		(4) 80%
Social Dimension	27	11%	√	√	√	√	√	(5) 100%

Setting Analysis by Specific Units

Eleven (55%) of the twenty attributes (communication, respect for patients, patient-centered care, comfort and pain, professionalism and trust, access to care, information and education, clinical care and staff competency, transitions and continuity, safety and security, and emotional dimension) appeared across all of the settings.

Oncology

Many instruments were tailored to the oncology population affirming the importance of understanding the patient experience of this complex population. In the oncology setting, 18 of the 20 attributes were present. The attributes not present were ‘patient dependent features’ and ‘medication’. It was surprising that the ‘medication’ attribute was not noted or measured in the oncology setting since this population typically requires a large number of pharmacological interventions.

Psychiatry and Rehabilitation

‘Discharge from hospital’, ‘hospital environment’, and the ‘social dimension’ attributes appeared in all of the settings except psychiatry. Although, the ‘global rating’ attribute did not appear in the psychiatry or rehabilitation and geriatrics settings, these settings had a small sample size, representing only 3% of the data collectively.

Grouping Settings Together

All Inpatient Units Included as the Setting

Articles which stated, “all inpatient units included” (N= 79; 31%) as their setting, were not included in the analysis of the settings as it is unknown which setting their results represented the most. Additionally, all 20 attributes and 62 out of 67 features were present in this category. Features not presented were ‘cognitive aspects’, ‘physical aspects’, ‘existential

aspects', 'transitions of care between hospital units', 'consistency of staff', and, 'patient's comprehension of information'.

Studies with No Setting

Moreover, we excluded articles that did not have a setting (N=41; 16%) from the analysis of the settings. All features were present in this category except 'patient readiness for discharge', 'discharge education about medications', 'overall care from all other healthcare professionals', 'empathy towards patients', and, 'hospital living arrangements.'

Critical Care versus Inpatient Units Analysis

When grouping settings by critical care versus all non-critical inpatient units, all twenty attributes emerged in both groups. This presented the generality of the attributes, as they were present in both critical care settings and generalized inpatient units. During further analysis, at the individual hospital unit level and feature level, more variation was present. For example, ICU dominated in the 'patient dependent features' attribute across all four features, especially in the 'cognitive aspects' feature 85% (N=11). Meanwhile, the 'patient dependent features' attribute was not present in the Emergency Department setting, while the 'hospital processes' attribute was not present in the ICU setting but is noted in the ED literature.

Table 4.5 Summary Table of Acute-Care Units and Relevant Attributes

			Med-Surg	Spec. Care	Onc.	ICU	Gyne	ER	Rehab	Psych		All Units	N/A	All Units Except Psych
# of Articles (N)			82	21	18	13	11	10	4	4		64	41	15
% of Total			32%	8%	7%	5%	4%	4%	2%	2%		25%	16%	6%
Attribute											#of units (N=8) 100%			
Communication	163	63%	√	√	√	√	√	√	√	√	(8) 100%	√	√	√
Respect for Patients	125	49%	√	√	√	√	√	√	√	√	(8) 100%	√	√	√
Information and Education	124	48%	√	√	√	√	√	√	√	√	(8) 100%	√	√	√
Patient- Centered Care	118	46%	√	√	√	√	√	√	√	√	(8) 100%	√	√	√
Comfort and Pain	114	44%	√	√	√	√	√	√	√	√	(8) 100%	√	√	√
Professionalism and Trust	103	40%	√	√	√	√	√	√	√	√	(8) 100%	√	√	√
Clinical Care & Staff Competency	101	39%	√	√	√	√	√	√	√	√	(8) 100%	√	√	√
Access to Care	91	35%	√	√	√	√	√	√	√	√	(8) 100%	√	√	√
Transitions and Continuity	65	25%	√	√	√	√	√	√	√	√	(8) 100%	√	√	√
Emotional Dimension	64	25%	√	√	√	√	√	√	√	√	(8) 100%	√	√	√
Safety and Security	41	16%	√	√	√	√	√	√	√	√	(8) 100%	√	√	√
Discharge from Hospital	111	43%	√	√	√	√	√	√	√		(7) 87.50%	√	√	√
Medication	84	33%	√	√		√	√	√	√	√	(7) 87.50%	√	√	√
Interdisciplinary Team	28	11%	√		√	√	√		√	√	(7) 87.50%	√	√	√
Social Dimension	27	11%	√	√	√	√	√	√	√		(7) 87.50%	√	√	√
Hospital Environment	110	43%	√	√	√	√	√	√			(6) 75%	√	√	√
Global Ratings	90	35%	√	√	√	√	√	√			(6) 75%	√	√	√
Outcomes	49	19%	√	√	√	√	√			√	(6) 75%	√	√	√
Hospital Processes	43	17%	√	√	√			√			(4) 50%	√	√	√
Patient Dependent Features	13	5%	√	√		√					(3) 37.5%	√	√	

Model Case

The model case is a hypothetical scenario that includes all of the attributes [1] relating to the patient experience. Karen is an oncology patient who lives in Ontario, Canada. Karen lives close to her local hospital and has access to free healthcare (**Access to Care**). Karen visits the Emergency Department (ED) where she is greeted promptly by staff and during her stay in the hospital, all of the healthcare staff, especially the nurses and doctors, communicated with her in a friendly, respectful and polite manner (**Communication; Respect for Patients**). The staff, especially the doctors, spent enough time with Karen to answer all of her and her family's questions and listened carefully to Karen's and her family's preferences for care (**Communication; Patient-Centered Care**).

While in the ED Karen was admitted to the medical-oncology unit, she was quickly transferred to her new room in a coordinated manner and received a friendly welcome from the new staff (**Communication; Respect for Patients; Continuum of Care/ Transitions and Continuity; Access to Care**). During examinations, treatments and discussions, Karen received complete privacy (**Respect for Patients**). All of the patients on Karen's unit were treated with equality and without discrimination by the staff (**Respect for Patients**). Karen's pain was adequately managed, and her symptoms and physical comfort were acknowledged and treated (**Comfort and Pain Management; Medication Management**). The hospital's facilities were clean, the environment was aesthetically pleasing, the temperature was comfortable, there was no unpleasing odour, the noise level was low inside and outside of Karen's room, and equipment and supplies were readily available and in stock (**Hospital Environment**). Most importantly, Karen felt safe at the hospital, at all times (**Safety and Security**).

It was easy for Karen to order and receive quality, tasty food (**Hospital Environment**). Karen did not have to share facilities with the opposite sex, and her

roommates were pleasant (**Social Dimension**). The respect between healthcare providers was evident to Karen as she observed many of their interactions and the nurses and doctors were professional at all times (**Interdisciplinary Team**). Karen had trust and confidence in her healthcare team and was overall satisfied with the care provided (**Professionalism and Trust**).

The hospital staff was available and responded to Karen's promptly such as support for self-care and activities of daily living (**Clinical Care & Staff Competency**). They also provided emotional support when Karen was feeling anxious (**Emotional Dimension; Patient Dependent Features**). Scheduled tests, such as X-rays were well coordinated, comfortable and timely. Karen perceived the nurses and doctors as competent in terms of technical skills, knowledgeable about her diagnosis and the treatment plan (**Clinical Care & Staff Competency; Access to Care**). When Karen complained of nausea, she received immediate supportive interventions (**Clinical Care & Staff Competency**). During Karen's stay at the hospital, she consistently had the same doctor and the same few nurses to care for her (**Clinical Care & Staff Competency**).

Verbal and written information was provided to Karen about tests, procedures, medication, discharge and all other aspects of her care (**Information & Education**). The information provided was accurate, consistent, and tailored directly to her (**Information & Education**). Before any care provision, options for treatment were provided, Karen's level of preparation was considered, and Karen served as an active participant in care decisions (**Patient-Centered Care**). Karen's readiness for discharge was considered, and staff took time to educate Karen and her family regarding the discharge process, danger signals to watch for once at home, medications, Karen's disease, and infection control (**Patient-Centered Care; Discharge from Hospital**). Staff also ensured that Karen and her family understood the information provided to them (**Information and Education**). A safe and coordinated

discharge was organized for Karen with a smooth transition of information to her family doctor and community care and services (**Discharge from Hospital; Continuum of Care/ Transition and Continuity**).

Overall, Karen felt that she had a good experience and highly recommended the hospital to a friend (**Global Rating**). Karen was satisfied with the care she received; she attributed a lot of her satisfaction to the prompt care she received from the nurses (**Outcomes**). Karen felt the adequate number and availability of nurses on the unit contributed to her overall experience (**Hospital Processes; Global Rating**).

Borderline Case

The borderline case is a hypothetical scenario which is missing one or more of the attributes [1] relating to the patient experience. Karen is an oncology patient who lives in Ontario, Canada. Karen lives far away from a hospital and has difficulty accessing healthcare. Karen drives two hours to the nearest hospital and visits the Emergency Department (ED). Once in the ED, Karen is greeted promptly by staff and during her stay in the hospital, all of the healthcare staff, especially the nurses and doctors, communicated with her in a friendly, respectful and polite manner (**Communication; Respect for Patients**).

While in the ED, Karen waited two days before receiving a transfer to the medical-oncology unit. The transfer seemed uncoordinated and delayed, but once on the medical-oncology unit she received a friendly welcome from the new staff (**Communication; Respect for Patients**). During examinations, treatments and discussions, Karen received complete privacy (**Respect for Patients**). Karen's pain was inadequately managed, and her symptoms and physical comfort were not acknowledged or treated effectively.

While Karen felt safe at the hospital, she was disappointed with the lack of cleanliness of the washrooms (**Safety and Security**). The hospital's facilities seemed in need of a

renovation, it was cold at night, she shared facilities with the opposite sex, and frequently, there was an unpleasant odour in the air.

Karen was frequently did not receive her meals, and when she did, the food not appetizing. While Karen had trust and confidence in her doctors and nurses (**Professionalism and Trust**), at times the interaction between the healthcare staff seemed hostile and tense.

The nurses seemed inadequately staffed as responses to Karen's requests for support and activities of daily living were delayed. Karen was happy with the care she received, once the nurses responded. She especially liked the emotional support they provided when Karen felt anxious (**Emotional Dimension; Patient Dependent Features**). Scheduled tests, such as X-rays were well coordinated, comfortable and timely. Karen perceived the nurses and doctors as competent in terms of technical skills, knowledgeable about her diagnosis and the treatment plan (**Clinical Care & Staff Competency; Access to Care**). During Karen's stay at the hospital, she frequently had a new doctor and new nurses to care for her and felt there was a lack of inconsistency in her healthcare team.

Verbal and written information was provided to Karen about discharge, but she did not receive information about her medications and scheduled tests (**Information & Education**). The information provided seemed inconsistent generalized to all oncology patients. Karen's readiness for discharge was not considered, and the discharge process seemed uncoordinated especially since her family doctor was unaware of her hospital visit. Overall, Karen felt that she had a mediocre hospital experience and did not recommended the hospital to a friend.

Contrary Case

The contrary case is not the patient experience and omits many of the critical attributes [2]. Karen is an oncology patient who lives in Ontario, Canada. Karen lives far away from a hospital and has difficulty accessing healthcare. Karen eventually visits an E.D. where the

staff does not greet her, and she is left to wait, feeling ignored. During her stay in the hospital, all of the healthcare staff, especially the nurses and doctors, barely communicated with her and when they did it was in a rude and at times disrespectful manner. The staff, especially the doctors, did not spend time with Karen and all of hers and her family's questions went unanswered.

Karen waited in the ED to transfer to the medical-oncology unit for days. When the transfer finally occurred, it was uncoordinated, and she was left to wait in the hallway on the unit while the staff tried to find a room for her. She felt unwelcome on the new unit and staff did not bother to introduce themselves. During examinations, treatments and discussions, Karen was not provided with privacy, and her roommates could hear everything about her medical care. At times Karen felt certain patients were mistreated and were discriminated against by the staff.

When Karen complained of pain, she did not receive adequate management and continued to feel physically uncomfortable. The hospital's facilities were unclean, the temperature was cold, and there were many unpleasing odours. The noise level was loud inside and outside of Karen's room, and it seemed that equipment and supplies were never in stock. Many times, Karen did not receive a food tray and was seemingly missed for meal delivery, and when she did receive meals, the food tasted terrible and seemed to be of low quality. Karen shared a room with individuals of the same sex, and she found her roommates to be pleasant (**Emotional Dimension; Patient-Dependent Features**).

Karen observed many interactions between the nurses and doctors and found them to be disrespectful towards each other, unprofessional at times, and inconsistent with the information provided. Karen lacked trust and confidence in her healthcare team and left feeling unsatisfied with the overall care provided to her. Karen perceived the nurses and doctors as incompetent in terms of technical skills, knowledgeable about her diagnosis and the

treatment plan. During Karen's stay at the hospital, she had numerous doctor and nurses caring for her and could not keep track of their names and roles.

Karen found it difficult to get help with activities of daily living and the staff took a long time to respond to her call bell as the nurses seemed understaffed. Scheduled tests, such as X-rays were uncoordinated, at times uncomfortable and frequently delayed.

There was a lack of information provision about tests, procedures, medication, discharge and all other aspects of her care. When Karen did receive information, it was inaccurate, inconsistent and generalized for all patients. Karen did not receive options for care, was not involved in decisions regarding her care, and her level of preparation was not considered before treatments.

Karen felt unready for discharge; the staff did not educate Karen and her family regarding the discharge process, danger signals to watch for once at home, medications, Karen's disease, or infection control. Karen left home feeling unsafe, unprepared and lacking information on how to proceed. Her family doctor was not updated on Karen's hospital stay, and she did not receive the community services she felt she desperately needed.

Identifying Antecedents and Consequences

Antecedents. Antecedents are events or incidents that occur before the patient experience (the concept) and may include events, behaviours, or environmental characteristics, that temporally or theoretically precede and influence the concept [1]. Due to the all-encompassing nature of the patient experience, there were a small number of antecedents. The antecedents of the patient experience are (1) the patient's severity of illness requiring care [3]; (2) the patient's and staff's ability to hear what is said [4]; (3) patient activation [5]; and (4) "a feedback loop that enables improvement conversations about the breadth and depth of an individual's or organization's patient-centeredness" [4].

Consequences. Consequences are anticipated events, behaviours, or conditions that follow the implementation of patient experience as a concept [1]. Consequences include (1) measures of the patient experience [4]; (2) hospital reporting of the patient experience scores [6]; (3) changing practice, policies and rules based on the patient experience data [4]; (4) quality of care [7, 8]; (5) the staff's and hospital's reputations [9]; (6) hospital funding and costs [10]; (7) reduced patient decision conflict [11]; (8) a more efficient healthcare system [12]; (9) performance improvement efforts [13]; (10) staff disengagement [14]; (11) patient's length of stay [13]; (12) hospitals remaining competitive in the healthcare market [9]; (13) staff retention [14]; (14) patient retention [14]; and, (15) adherence to medications and treatment [8].

Defining Empirical Referents

To define the empirical referents, we included all articles that discussed any patient experience measurement instruments. The list of twenty attributes also served as the defining empirical referents for the patient experience. Table 4.6 provides a list of titled patient experience instruments used in the analysis, while the 35 unnamed instruments are not included.

Table 4. 6 Complete List of Titled Instruments Used to Measure the Patient Experience (Does not include 35 unnamed instruments.)

A&E Department Patient Survey 2014
A&E Department Questionnaire
Adult Inpatient Experience (English)
Canadian Patient Experiences Reporting System (CPERS)
Canadian Patient Experiences Survey- Inpatient Care (CPES-IC)
Cancer Patient Experience Survey/ National Cancer Patient Experience Survey (NCPES)
Consumer Quality Index (CQI) Inpatient Hospital Care Questionnaire
Patient Experience of Dutch Inpatient Hospital Care Survey
Consumer Quality Index Hip Knee Questionnaire
Cultural Competency Assessment Tool for Hospitals (CCATH) Survey
Emergency Department Patient Experience of Care (EDPEC) Survey
Experiences of Nursing Care Scale
Family Satisfaction in the ICU Survey (FS-ICU 24)
Flemish Patient Survey
Friends and Family Test (FFT)
General Inpatient Questionnaire (GIQ)
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
Hong Kong Inpatient Experience Questionnaire (HKIEQ)
howRwe
Inpatient Assessment of Health Care (I-PAHC)
Inpatient Experience Questionnaire
Inpatient Survey - NHS England's Patient Experience Tool (2002, 2007, 2008, 2010, 2013)
Intensive Care Experience Questionnaire (ICEQ)
Irish National Perception of Quality of Care Survey (INPQS)
Medicare Consumer Assessment of Healthcare Providers and Systems (MCAHPS) Survey (2013)
Multimedia Intervention for Managing Patient Experience (MIME)
National Health Service Survey –fifth (NHSS)
National Patient Experience Survey
Newcastle Satisfaction with Nursing Scale (NSNS)
NHS National Adult Inpatient Survey (NHS NAIS)
Nordic Patient Experience Questionnaire (NORPEQ)
OxPIE Oxford Patient Involvement and Experience Scale
Patient Dignity Inventory
Patient Evaluation of Emotional Care during Hospitalization (PEECH)
Patient Experience of Care (PEOC) Dimensions
Patient Experience and Consumer Engagement: A Framework for Action
Patient Experience of Dutch Inpatient Hospital Care Survey
Patient Experience Improvement Framework
Patient Experience Questionnaire (PEQ)
Patient Experience Surveys (PES)
Patient Measure of Safety (PMOS)
Patient Perception of Quality (PPQ)
Patient Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ)
Patient's Assessment of Quality Scale- Acute Care Version (PAQS-ACV)
Patients' Evaluation of Performance in California (PEP-C survey)

Perceived Hospital Environment Quality Indicators (PHEQI)
Picker Inpatient Experience Survey- Picker Problem Score (PPS)
Picker Institute - Adult Inpatient Survey
Picker Patient Experience Questionnaire (PPE-15)
Picker Patient Experience Questionnaire (PPE-40)
Psychiatric Inpatient Experience Questionnaire (PIPEQ)
Psychiatric Inpatient Experience Questionnaire- On Site (PIPEQ-OS)
Press Ganey Emergency Department Survey
Press Ganey Inpatient Survey
Quality from the Patient's Perspective Questionnaire (QPP)
Quality from the Patients' Perspective Shortened (QPPS)
Quality of Care Questionnaire
Quality of Interaction Schedule (QuIS)
Quality of Trauma Care Patient - Reported Experience Measure (QTAC-PREM)
Scottish Inpatient Patient Experience Survey (SIPES)
Short Form- Hong Kong Inpatient Experience Questionnaire (SF-HKIEQ),
Survey of Healthcare Experiences of Patients (SHEP)
Swedish version of the Picker Patient Care Experience -15 (PPE-15)
The Cancer Patient's World (CPWQ) Questionnaire
The CareWell in Hospital Questionnaire
The Faces of All Clinically Engaged Staff (FACES) Instrument
The Perceptions of Care (PoC-24)
Three-Item Care Transitions Measure (CTM-3)
Urgent Care System Questionnaire (UCSQ)
Views on Inpatient Care (VOICE)
Warwick Patient Experience Framework (WaPEF)

Discussion

As noted earlier, while this is the first formal concept analysis of the patient experience, Wolf and colleagues [15] published an article to determine explicit definitions of the patient experience in the literature, the common overarching themes, and constructs that should be considered [15]. Although this study aimed to find definitions of the patient experience, the limitations of this study potentially affected the findings. Below, I will discuss the study by Wolf and colleagues [15] and how my concept analysis builds upon and presents further findings.

Methods Comparison

The literature search for this concept analysis was more comprehensive in comparison to Wolf and colleagues [15], as their search yielded 2,254 sources (articles and organizational websites), while ours yielded 12,676 sources. Their study included a total of 18 sources, while this concept analysis included a total of 257 sources.

Wolf and colleagues [15] did not use a framework for guidance of their research study while we utilized Walker and Avant's [1] concept analysis methodology to guide the process, ensuring a comprehensive and systematic approach. They limited their literature search to a 14-year time period from 2000 to 2014 [15], whereas our study did not have any time limitations for the literature search and all literature published up until March 2018 was considered.

Wolf and colleagues' [15] excluded all operational definitions including instruments used to measure the patient experience, and any articles that contained but did not explicitly define the term patient experience, therefore, excluding all articles that discuss the various attributes and aspects of the concept. Excluding articles, which contain The Beryl Institute's [16] and the Institute for Healthcare Improvement's [17] definitions, potentially omits any articles that modify or expand on these already existing definitions. Our study included all definitions of the patient experience: operational and theoretical. This resulted in the analysis containing 104 unique patient experience measurement instruments and 22 theoretical definitions, compared to zero operational definitions and 18 theoretical definitions in Wolf and colleague's [15] study analysis.

Results Comparison

Wolf and colleagues' [15] study identified several overarching themes and recommendations to consider regarding the definitions of the patient experience:

1. continuum of care;

2. beyond survey results;
3. focus on expectations;
4. aligned with patient-centered care principles;
5. focus on individualized care; and,
6. more than satisfaction.

All findings and considerations study were also echoed in my concept analysis, with the addition of numerous attributes and features. Overall, my concept analysis yielded twenty attributes and 67 features. ‘Continuum of care’, and ‘patient-centered care’ are both independent attributes in my concept analysis, while focus on ‘individualized care’ is a feature of the ‘patient-centered care’ attribute. ‘Overall satisfaction’ is categorized as a feature of the ‘outcome’ attribute, while ‘focus on expectations and beyond survey results’ are dispersed across a few features. ‘Beyond survey results’ argues that the patient experience should be defined more broadly than the HCAHPS [18] survey domains, as it does not encompass the breadth and depth of the patient experience. Citing Beyond Philosophy [19] further explaining that the patient experience is about the whole organization delivering, the emotional experience and intuitive perceptions of patients [15]. The ‘beyond survey results’ theme is dispersed across a few features in my concept analysis such as: ‘overall hospital rating’, ‘overall experience’, ‘emotional support’, and ‘emotional status’.

‘Focus on expectations’ refers to whether the patient’s expectations were met during their healthcare visit [15]. This theme potentially adds to concept confusion, as meeting of expectations is a measure of patient satisfaction and not patient experience [20-22]. Wolf and colleagues [15] cite Bowling and colleagues [23] as the source of this theme. Patient satisfaction has been referred to as the difference between the patient’s expected care and the actual care received [6, 20-22, 24]. Patient satisfaction is determined by expectations while patient experience aims to obtain factual data of what occurred during the healthcare visit

[22]. The expectations Wolf and colleagues [15] list (e.g. cleanliness, information about where to go, convenient and punctual appointments, doctor being respectful and treating with dignity) are all present in the features of our concept analysis. All of the examples they included of the patient “expectations” are accounted for in our concept analysis of the patient experience.

The extensive list of attributes and features can be found in Table 4.3 which include the six themes found by Wolf and colleagues [15] but further expands and includes the addition of numerous attributes and features. Out of the twenty attributes found in our concept analysis, nine are missing from Wolf and colleagues’ [15] study: ‘discharge from hospital’, ‘professionalism and trust’, ‘clinical care and staff competency’, ‘access to care’, ‘medications’, ‘global ratings’, ‘interdisciplinary team’, ‘outcomes’, and ‘social dimension’.

Overall, our study built upon the work by Wolf and colleagues [15] to provide a comprehensive concept analysis of the patient experience providing additional attributes, features, and overall clarity to the concept of the patient experience.

Strengths and Limitations

Although using Walker & Avant's [1] methodology as a guide for the concept analysis helped focus the data extraction on findings relevant to the review question some limitations to the study exist. First, this concept analysis only included articles that used the term patient experience explicitly in the gathering of attributes. There are a variety of ways to express the concept of patient experience beyond the use of the exact term in the literature; therefore, some references might have been missed. Second, the inclusion of related terms in the initial literature search would have been ideal for assembling a more inclusive scope of the overall concept. A calculated decision was made to limit the search to the use of the exact term in order to narrow the results into a feasible number of articles for the purposes of this thesis.

Words related to the patient experience may merit separate concept analyses to guide their use in the clinical setting.

Conclusion

Patient experience is recognized as one of the three pillars of quality healthcare, alongside clinical effectiveness and safety [8, 25]. Data resulting from measuring the patient experience is used to direct limited resources; however, there is a lack of consensus on the definition and the identifying attributes of the patient experience. A concept analysis using Walker and Avant's [1] eight-step systematic approach was performed and identified 67 features categorized into twenty defining patient experience attributes: (1) communication; (2) respect for patients; (3) information and education; (4) patient-centered care; (5) comfort and pain; (6) discharge from hospital; (7) hospital environment; (8) professionalism and trust; (9) clinical care and staff competency; (10) access to care; (11) global ratings (12) medication; (13) continuum of care/ transitions and continuity; (14) emotional dimension; (15) outcomes; (16) hospital processes; (17) safety and security; (18) interdisciplinary team; (19) social dimension; and, (20) patient dependent features.

A model, borderline, and contrary case demonstrated the patient experience in a hypothetical patient scenario to distinguish the critical attributes. This concept analysis identified four antecedents, fifteen consequences, and 104 empirical referents of the patient experience.

Finally, we compared the results of this study to those of Wolf and colleagues' (2014) study 'Defining the Patient Experience' to distinguish the similarities, disparities, and how this concept analysis advances their work. Overall, this comprehensive concept analysis of the patient experience provided conceptual clarity to the term 'patient experience' by determining its defining characteristics.

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Chapter Five

Integrated Discussion

Integrated Discussion

This chapter includes an integrated discussion between the literature review (Chapter Two) and the results of the concept analysis (Chapter Four). I will also discuss the implications for hospitals, nursing practice, policy and research.

Summary of Thesis Findings

Literature Review

In my preliminary literature review (Chapter Two), the aim was to identify and summarize the existing theoretical definitions of patient experience and describe the relevant patient experience frameworks. The search was conducted using three healthcare literature databases (PubMed, MEDLINE, CINAHL) and one search engine (Google), limited to the hospital setting and adult population.

Results of the literature review revealed 26 relevant articles and organizational websites. I grouped the results into two categories: theoretical definitions, and patient experience frameworks. The literature review identified seven unique theoretical definitions of the patient experience and seven unique patient experience frameworks: three seminal patient-centered care frameworks, and four patient experience frameworks.

While the literature review revealed a lack of consensus on the definition of the patient experience, one comprehensive theme emerged: ‘personal interaction and patient engagement’ which was present in 18 [1-17] of the 26 articles. The theme of ‘continuum of care’, was cited in the theoretical definitions but missing from all patient experience frameworks, and ‘culture’, appeared in six articles but only one framework [18].

The patient experience frameworks showed more comprehensive patient experience domains compared to the theoretical definitions. ‘Respect for patient values and preferences’

was found across all seven frameworks and ‘coordination and integration of care’ was found in five frameworks, but neither theme was present in any of the theoretical definitions. Other themes found in the patient experience frameworks but missing from theoretical definitions are ‘emotional support’, ‘involvement of friends and family’, ‘transitions and continuity’, ‘physical comfort’, and ‘access to care’.

Concept Analysis

The aim of this study was to conduct a concept analysis to identify and analyze the existing definitions, theories, and measures of the patient experience. The concept analysis searched for theoretical and operational definitions of the patient experience, resulting in fourteen unique theoretical definitions and 105 unique operational definitions. Both theoretical and operational definitions were disassembled, assessed, combined into synonyms, and further organized into 67 features and twenty defining attributes.

‘Communication’ was the most frequent attributes, followed by ‘respect for patients’, ‘information and education’, and ‘patient-centered care’. The least frequent attributes were ‘patient-dependent features’, ‘social dimensions’, ‘interdisciplinary team’, and ‘safety and security’.

Integrated Discussion

The integrated findings from my literature review and my concept analysis of the patient experience in this thesis leads to a discussion of how the concept analysis compares to the literature review.

How My Concept Analysis Compares to the Literature Review

Theoretical Definitions

The literature review revealed seven unique theoretical definitions, while the concept analysis revealed fourteen unique theoretical definitions of the patient experience. In the concept analysis, of the eight sources (articles and organizational websites) that provided a theoretical definition, 37% (N=3) were from published articles, and 63% (N=5) were from unpublished sources. In the concept analysis, out of the twenty-two references (9%) that provided an explicit definition of the patient experience, thirteen were from an unpublished article [7, 8, 15, 19-28]. Overall, in the concept analysis, only nine (4%) published studies defined the patient experience theoretically. There is a noticeable lack of explicit definitions of the patient experience in published literature both in the literature review and in the concept analysis.

Sum of All Interactions

Some themes appeared commonly in the explicit definitions of the patient experience but were not mentioned frequently if at all in the patient experience frameworks in the literature review, and the operational definitions in the concept analysis. ‘Sum of all interactions’ is found in seven (32%) out of the twenty-two theoretical definitions [15, 16, 21, 24, 26, 29, 30] in the concept analysis, and three [8, 15, 16] of the eight definitions in the literature review.

Six out of the seven articles in the concept analysis, and two of the three from the literature review, that mentioned “sum of all interactions”, use The Beryl Institute’s [15]. Therefore, the theme of “sum of all interactions” is common in the literature because of The Beryl’s Institute’s [15] definition of the patient experience. Otherwise, ‘sum of all

interactions' was not found in any of the patient experience frameworks nor any of the instruments used to measure the patient experience.

In the concept analysis, no questions in the patient experience measurement instruments asked whether the patient's current hospital stay was influenced by previous hospital experiences or how their recent hospital experience may affect seeking future healthcare from the same hospital. While it would seem logical that patients are influenced and affected by their previous experiences while in the hospital, it is not found or measured in the operational definitions.

Continuum of Care

Continuum of care is one of the themes found in the literature review, referenced in 23% of the literature (N=6 articles and organizational websites), five theoretical definitions and one patient experience framework. This attribute is found in my concept analysis as an attribute, referenced in 25% of the included literature (N=65 articles and organizational websites). 'Continuum of care' is found in the operational definitions in the concept analysis by questioning patients about their patient experiences before entering the hospital and accessing care, to post-hospital discharge. Mostly, continuum of care is found in both the theoretical and operational definitions and is equally found in the literature review and the concept analysis.

Personal Interaction and Patient Engagement

The literature review revealed 'personal interaction and patient engagement' as the dominant theme found in 18 [1-17] of the 26 articles (69%). This theme is also found in my concept analysis as the 'patient as active participant' attribute in 75 of the 257 articles (29%).

Attributes Present in Both the Literature Review and the Concept Analysis

The frameworks in the literature review provided attributes of the patient experience which include: 'respect for patient values and preferences'; 'coordination and integration of care'; 'information and education'; 'physical comfort and pain control'; 'emotional support'; 'involvement of family and friends'; 'communication'; 'nurses'; 'doctors'; 'cleanliness'; 'transition and continuity'; 'access to care'; 'patient as active participant'; 'culture'; 'safe dignified care'; 'workforce'; 'individualized approach'; 'lived experience'; and, 'leadership'.

The 'lived experience' attribute is referenced in The Warwick Patient Experience Framework as it encompasses everyday experience, hopes, expectations, future uncertainty, feelings of loss, feelings of being morally judged, and feelings of blame [11]. The 'lived experience' is represented by the 'patient dependent features' attribute which is comprised of 'emotional status', 'physical abilities', 'cognitive capacity' and, 'existential aspects.' The 'patient dependent features' attribute is the least of the twenty attributes and is found in 13 of the 257 articles (5%) in the concept analysis.

All of the attributes listed in the patient experience frameworks were found in the concept analysis, except for 'leadership' [18]. 'Leadership' was not found in any of the attributes of features in the concept analysis.

While the theoretical definitions and the patient experience frameworks from the literature review attempt to create a unique understanding of the patient experience, they fail to capture the breadth of the issue and only form part of the full concept. For example, while 'communication' is found in the literature review, it is not expanded upon. In my concept analysis, 'communication' is the most dominant attribute as it was the most frequent in the literature (N=163; 63%) and is comprised of four features: 'doctor communication', 'nursing communication', 'communication by all staff', and, 'availability of staff to answer patient's questions.'

Patient Experience versus Patient Satisfaction

Patient experience and patient satisfaction are sometimes wrongfully used interchangeably [31, 32]. The two concepts are very different and a dominant perspective is that patient satisfaction is a subcategory of the patient experience [33]. Patient experience is a process of care [34] while patient satisfaction is a rating of the experience [35-38]. Patient satisfaction has been referred to as the difference between the patient's expected care and the actual care received [31, 39-42]. Patient satisfaction is determined by expectations that are likely to vary among cultural groups while patient experience aims to obtain factual data [40]. Patient experience questionnaires are considered more accurate compared to patient satisfaction questionnaires, as they are a measure of events that occurred as opposed to the patients' opinions of the experience [31, 40, 43, 44]. Essentially, patient satisfaction surveys elicit subjective data while patient experience surveys aim to elicit more objective information relating to aspects of care [40, 43]. Questionnaires that ask patients to rate their satisfaction with the care tend to elicit very positive rating [44, 45]. A more valid approach is to ask patients to report on the details of their experience by asking specific questions about processes and events [6, 44, 45].

Quality of Care and the Patient Experience

Accompanying the stressed importance on patient experience is emerging evidence of an association between patient experience and quality of care [3, 46]. Patient experience is as a measure of the quality of care from the patient's perspective [19, 41, 47-51]. The patient experience reflects "key aspect of inpatient care from patients' perspective as well as facilitate[s] quality improvement by cultivating patient engagement" [50] (p.1). Furthermore, some aspects of healthcare quality can only be reported on by the patients themselves, for example the quality of communication from healthcare staff [52]. In this sense, patient

experience serves as an opportunity for healthcare providers to improve their care [52].

Measuring the patient experience and using it, as an opportunity to change practice could be a solution to improving the quality of inpatient care [31].

The Institute of Medicine [6] lists six domains of health care quality: safe, effective, patient-centered, timely, efficient, and, equitable. In the literature, emphasis is placed on the patient experience reflecting the patient-centered care domain of quality care [31, 52], we argue that all six domains of healthcare quality are all represented by patient experience attributes.

Safety

Safety is “avoiding harm to patients from the care that is intended to help them” [6]. During our concept analysis we found ‘safety and security’ is an attribute of the patient experience and positive patient experience have been linked to decreased inpatient care complications such as particularly decubitus (pressure) ulcers and post-operative respiratory failure [53]. Furthermore, hospitals with positive patient experience scores tend to have more positive perceptions of patient safety culture among staff [54, 55].

Effective Care

Effective care is “providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit” [6]. This domain reflects the clinical ‘outcomes’ of care attribute as it includes the accuracy of the treatment provided and the individualized care feature from the ‘patient-centered care’ attribute. Several studies have examined links between patient-reported experiences and clinical outcomes [56-61].

Patient-Centered Care

Patient-centered care is defined as “providing care that is respectful of an responsive to individual patient preferences, needs, and value and ensuring that patient values guide all clinical decisions” [6]. ‘Patient-centered care’ is its own patient experience attribute, and includes features of individualized care, options for care, and patient preferences.

Additionally, Respect for Patients is represented as its own attribute.

Timely Care

Timely care is referred to as “reducing waits and sometimes harmful delays for both those who receive and those who give care” [6]. Again, this domain is in direct alignment with the patient experience attribute: ‘access to care’, especially the feature waiting time and delays.

Efficient Care

The ‘efficient care domain’ is defined as “avoiding waste, including waste of equipment, supplies, ideas, and energy”. This domain aligns with the ‘access to care’ attribute as the care coordination feature pertains to efficient and well-organized process of care. Boulding and colleagues [62] found that patients' overall ratings of hospitals' care and discharge planning were independently associated with lower 30-day readmission rates for acute myocardial infarction, heart failure and pneumonia patients.

Equitable

Lastly, the equitable domain is “providing care that does not vary in quality because of personal characteristics such as gender, ethnicity geographic location, and socioeconomic status” [6].

The Patient Experience and Hospital Financing

A significant shift has occurred with healthcare leaders investing a great deal of money and resources into encouraging and improving the patient experience [63]. Enhanced patient experience is associated with decreased medical malpractice risk [64]. Patient experience measures drive hospital incentive payments and are linked with increased profitability [65]. In the United States, a study found that hospitals with the highest patient experience performance were also the most profitable [66]. Another study linked patient experience with patient retention rates as physician practices with poor reported patient experience measures were three times more likely to have patients voluntarily leave their practice [67].

Significance of the Patient Experience for Hospitals

As healthcare is more business driven than ever before, it is more crucial than ever for hospitals to stay competitive in the healthcare market. Patient experience is a key metric that many are trying to attract and improve. Globally, for for-profit hospitals, the insurance and cost of care often drive patients to seek care from a specific hospital, therefore, creating a lack of choice, but for the most part, patients have more options for healthcare than ever before [55]. Hospitals acknowledge that patients have a choice of healthcare, increasing the competition in the healthcare market.

Literature revealed that hospitals in the United States with the highest patient experience scores are the most profitable [66] and physicians have higher patient retention rates [67]. In the United States, a hospital's value proposition is to get insurance contracts, and this is often based on patient experience scores [55].

Significance of the Patient Experience for Hospitals in Canada

In Canada, patient experience measures drive hospital incentive payments and are linked with increased profitability [65] and reduced medical malpractice risk [64]. Even though the majority of Canadian hospitals are run by non-profit organizations, the changes in the structure of healthcare and funding have intertwined patient experience with financing and reimbursements.

In Ontario, The Excellent Care for All Act (2010) [68] requires hospitals to establish patient relations processes to improve the patient experience. This act is essentially the foundation for benchmarking hospitals in Ontario and influences the rest of the healthcare system including legislation and targets.

The Ministry of Health and Long-Term Care in Ontario has implemented the Patients First: Action Plan for Health Care Act [69], which is the government's plan for the next phase of health-care transformation [70]. Created in 2012, The Patients First: Action Plan for Health Care [69] is centered on improving the patient experience of healthcare [69].

Funding is dedicated to hospitals that meet specific metrics such as patient experience scores [71]. Quality-Based Procedures (QBP) compensation structures were implemented for hospitals to receive compensation for meeting targets [72]. Hospitals are non-for-profit institutions but are also the only institutions allowed to keep the profits they make. If a hospital ends up in surplus at the end of the year, they can then use that money to invest in whatever they please, including new equipment.

Hospital Funding Models

Hospitals receive funding through three models: (1) the Health-Based Allocation Model (HBAM) [73] (2) the Quality-Based Procedures model [72] and, (3) Linking Quality to Funding (LQ2F) [74]. The Health-Based Allocation Model (HBAM) [73] is a population-

based model, where funding is allocated for hospital growth and other initiatives based on the demographic and environmental context.

Quality-Based Procedure (QBP) Funding Model

The Quality-Based Procedures (QBP) [72] model is based on diagnosis-related groups, which promotes standardized treatments and inpatient admission time based on the patient's diagnosis [72] by benchmarks set by the Discharge Abstract Database (DAD) [75]. The method of creating benchmarks and measurements for patients with similar diagnoses is the use of a Discharge Abstract Database (DAD) by the Canadian Institute for Health Information (CIHI) [75]. DAD captures administrative, clinical and demographic data on hospital discharges [75]. For example, for a patient requiring a knee replacement, the mean cost and length of stay are calculated for each age range group, and the patient is placed somewhere within a mean of costs and length of stay, therefore, the hospital only receives a set amount of money for that patient. However, if that patient develops a complication and requires a longer length of stay, the hospital does not receive additional funding, contrarily, if the patient is discharged sooner than expected, the hospital gets to keep the difference in money, and that is how hospitals make a profit off of patients using the Quality-Based Procedures (QBP) model.

Linking Quality to Funding (LQ2F) Model

The Linking Quality to Funding (LQ2F) [74] model project was created in 2018 by the Hospital Advisory Committee (HAC) as a recommendation on improving the Health System Funding Reform (HSFR) that is in alignment with the Excellent Care for All Act (2010) [68] and the Patients First Act, 2016 [69]. The Linking Quality to Funding (LQ2F) [74] was implemented in 2018 by the MOHLTC in conjunction with the Ontario Hospital Association (OHA) after recommendations from the HAC [74]. This model links funding to three quality

indicators: patient-centeredness, effectiveness, and safety [74]. “By assessing how hospital funding could incentivize improved care quality, LQ2F will build upon the success of Health System Funding Reform (HSFR) and support HSFR’s aim to better align funding with the delivery of quality care and improved health outcomes. The project will use a shadow-billing approach to demonstrate to each acute care hospital how indicator performance would theoretically impact funding”[74] (p.3).

The three areas of focus are patient experience, medication reconciliation at discharge, and 30-day readmission [74]. There are five measures of these areas of focus, and three of them are solely based off patient experience representing the entirety of the patient-centeredness quality indicator. The patient-centeredness quality indicator is based off three questions from the Canadian Patient Experience Survey- Inpatient Care (CPES-IC) [74] : (1) Did you feel there was good communication about your care between doctors, nurses and other hospital staff?; (2) Before you left the hospital, did you have a clear understanding about all your prescribed medications, including those you were taking before your hospital stay?; and, (3) Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? The first question is used as a reflection of care coordination, while the other two are used as a reflection of post-discharge management. All three items are aligned with the Patient First Act, 2016 and positively correlated with the patients’ overall hospital rating [74].

The Canadian Patient Experience Survey- Inpatient Care (CPES-IC) is a standardized questionnaire created by the CIHI that meets Accreditation Canada requirements for patient experience surveying [74]. Canadian Patient Experiences Survey - Inpatient Care (CPES-IC) data is accessed by the Ontario Hospital Association (OHA) through CIHI’s patient experience portal and reported to the ministry for comparative analysis [74].

The Importance of the 'Discharge from Hospitals' Attribute for Hospitals and Patients

The QBP model for funding establishes a culture where if a patient stays longer than allocated for their diagnosis, the hospital will lose money. Since hospitals are the only institution allowed to make profits, they must invest their time and resources to discharging patients as soon as possible so that they can turn over a profit and invest the surplus of money into innovations.

Our study found that in Canada, only 1 out of the 16 (6%) included articles mentioned patient readiness for discharge as part of the patient experience even though hospitals are monitored on a patient's 30-day readmission rate in Canada and the patient's experience surrounding the discharge processes is part of the LQ2F funding model [74]. A systematic review of 34 studies, based on retrospective chart review, found the median proportion of preventable readmissions was 27% but ranged from 5 to 79% [76]. Another study looked at the causes of readmission and stated early discharge as a primary cause, and one-half of potentially preventable readmissions were linked to interventions that could have been provided during the initial hospitalization [77].

Implications for Nursing Practice

From a nursing perspective, patient experience is of crucial importance as nurses can help or hinder this issue. Nurses spend the most time with patients compared to any other healthcare providers and are in the best position to fostering patient engagement and improving the patient experience [78].

Nursing specific features (nursing communication, overall care received from nurses, nursing competence, nursing staffing levels) are present in (n=137) 53% of the included studies. Beside the four explicit nursing features, nurses have an impact on many of the other features such as staff responsiveness, the discharge process, pain management, patient's

physical comfort, educating patients and family, treating patients with respect and dignity, and many others. Nurses have the heaviest influence on the patient experience of any health care providers, including doctors since nurses spend the most amount of time with patients, it seems logical that they would also have the greatest influence on the patient's experience of receiving healthcare [79].

Implications for Nursing Policy

College of Nurses of Ontario's Professional Standards

All seven of the College of Nurses of Ontario's Professional Standards [80] have a direct relationship to the patient experience attributes, especially the nursing specific attributes. The seven professional standards of practice are accountability, continuing competence, ethics, knowledge, knowledge application, leadership, and, relationships which consists of therapeutic nurse-client relationships and professional relationships.

Accountability

A nurse can demonstrate accountability through: (1) the nurse communication feature which includes identifying him/herself and explaining his/her role; (2) the interdisciplinary relationships feature by sharing his/her nursing knowledge and expertise with others to meet the patient's needs; (3) the patient safety feature by taking responsibility and appropriate action for errors and maintain patient safety; and, (4) the nursing staffing levels feature by ensuring that mechanisms allow for staffing decisions which are in the best interest of the patient [80].

Continuing Competence, Knowledge, & Knowledge Application

The continuing competence professional standard is reflected in the patient experience attributes as its own feature while the knowledge professional standard is closely tied.

Nursing competence is the “nurse’s ability to use his/her knowledge, skill, judgment, attitudes, values and beliefs to perform” [80] (p.g.5) in a changing healthcare environment. A nurse must obtain and share the required nursing knowledge to care for patients, including individualized care plans, and to ensure competence before performing any nursing skills.

Ethics

The ethics standard of professional practice [80] is directly aligned with the (1) patient preferences; (2) privacy; (3) discrimination; and, (4) equality features. A nurse can demonstrate this professional standard by respecting patient preferences, maintaining privacy and confidentiality, not discrimination against patients, and ensuring fairness in the use of resources [80].

Leadership

The leadership professional standard [80] can be demonstrated by collaborating with patients and the interdisciplinary team members to provide individualized patient care that respects the rights of patients, and role-modeling professional values. These correlate with the patient experience features: patient as active participant, interdisciplinary relationships, individualized care, and overall care received from nurses.

Therapeutic Nurse-Patient Relationship

Lastly, a nurse demonstrates a therapeutic nurse-patient relationship [80] by showing respect and empathy for his/her patients, developing collaborative partnerships, and fostering a safe environment while maintaining professional boundaries; and, interdisciplinary relationships by role-modeling positive collegial relationships and demonstrating respect for each other’s roles.

Implications for Nursing Research

This concept analysis identified important attributes and their features of the patient experience according to the literature, which can facilitate or hinder a positive patient experience. There is a need for a new patient experience framework, which identifies the specific attributes that, if addressed and met by the hospital and healthcare staff, will ultimately lead to a positive patient experience and overall better quality of patient care.

The attributes of the patient experience showed that, as healthcare professionals, nurses have the strongest potential impact on the patient experience. The creation of a new patient experience framework would guide researchers' assessments of the patient experience as well as the creation of proper and appropriate measurement tools. A patient experience framework would further provide conceptual clarity and would provide greater understanding of what strategies are likely to be effective in which circumstances. Acute-care hospital healthcare decision makers would be able to use the framework to pragmatically guide their implementation efforts by identifying the important attributes and features of the patient experience to consider when choosing and implementing interventions to improve the patient experience in their hospital.

There is also a need for a patient experience measurement instrument which takes into account all twenty of the patient experience attributes. Government healthcare decision makers would use the tool to accurately compare the patient experience scores across acute-care hospitals and allocate financing appropriately. Hospital healthcare decision makers would use the instrument to measure the patient experience within their hospital accurately and address certain needs based on the results.

Concluding Statements

In my thesis, I reviewed the literature on the theoretical and operational definitions of the patient experience. The literature review revealed a lack of consensus on the definition of the patient experience and revealed no study or concept analysis to provide concept clarity.

In my study, patient experience showed to be an all-encompassing concept with many features and defining attributes that are consistent across acute-care settings and countries. The significance of the patient experience in healthcare is consistent with the literature review, and while the attributes in the literature review were consistent in the concept analysis, they lacked breadth and depth. This resulted in the addition of numerous attributes and features of the patient experience.

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Appendices

Appendix A: Walker & Avant's Eight Steps

Step 1: Select the concept.	The concept of patient experience was identified due to its frequent references in the literature, often in association with initiatives for improved quality of care. Yet, a lack of consensus regarding a definition.
Step 2: Determining the aims and purpose of analysis.	<p>The purpose of this thesis is to conduct a concept analysis of the patient experience. This will involve the identification and the analysis of existing definitions, theories, and measures of patient experience to identify its defining attributes.</p> <p>The specific objectives of this comprehensive concept analysis of patient experience are to (1) provide conceptual clarity of the term patient experience, and, (2) determine its defining characteristics.</p>
Step 3: Identifying all uses of concept.	<p>To identify all uses of concept a comprehensive literature search must be conducted. The search strategy will start with searching bibliographic databases using the inclusion criteria. Databases PubMed, MedLine, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Nursing and Allied Health, Cochrane Database of Systematic Reviews, EMBASE, and ABI Inform will be searched for the term "patient experience" in the title, keyword, or abstract for the initial search.</p> <p>Additionally, I will conduct a secondary search by manually reviewing journals at the University of Ottawa's library. A manual search of reference lists of relevant papers and critical journals will also be conducted. To search for grey literature, I am going to use the search engine Google to search websites, which may contain information about patient experience or may have a definition of patient experience. Examples of sites include the Agency for Healthcare Research and Quality (2017) website, the Canadian Institute for Health Information (2017) website, The Beryl Institute (2017) website, the Patient Experience Summit (2017) website, and the Forbes (2015) magazine website.</p> <p>To search for grey literature the following strategies will be used: reviewing of abstracts from conferences, and a search for unpublished reports such as dissertations and theses (Polit & Beck, 2008). I will use ProQuest to search for theses.</p>
Step 4: Determine the defining attributes.	To complete this crucial step, after identifying all uses of patient experience, the identified uses will be examined carefully to find the attributes that are associated with the patient experience. A data

	<p>synthesis will be conducted, and a narrative review of the findings will be provided. To ensure an unbiased interpretation of the data, the process of identification of attributes, antecedents, and consequences will be verified by two individuals. Any attributes not noted by one reviewer will be discussed between the two reviewers and added if appropriate. Articles will be reread as necessary until no new insights on the attributes, antecedents, and consequences are identified. The list of attributes will also be assessed and synonyms will be combined. Then, the list will be further analyzed, organized and clustered into themes.</p>
<p>Step 5: Constructing a model case.</p>	<p>The model case is a scenario that includes all of the key attributes relating to patient experience. A model case will be constructed.</p>
<p>Step 6: Constructing additional cases.</p>	<p>Walker and Avant (2005) state constructing additional cases are important to distinguish the concept of patient experience from other concepts. The borderline case contains some of the critical attributes but not all of them, the related case is related to the patient experience but does not contain the critical attributes, the contrary case is not the patient experience, the invented case is constructed but has not existed in the real life, and the illegitimate case includes improperly using patient experience (Walker & Avant, 2005).</p> <p>A contrary case will be included in the concept analysis.</p>
<p>Step 7: Identifying antecedents and consequences. Antecedents are events or incidents that occur before patient experience (the concept) and may include events, behaviours, or environmental characteristics, that temporally or theoretically precede the concept. Consequences are anticipated events, behaviours, or conditions that follow the implementation of patient experience as a concept (Walker & Avant, 2005).</p>	<p>The antecedents and consequences will also undergo similar assessment and reorganization into themes as attributes, if applicable. Antecedents present in all included articles will be organized and reduced by eliminating repetition and collated into one list.</p> <p>Antecedents:</p> <ul style="list-style-type: none"> ○ The process of engagement from patient, caregiver or provider, as it may result in either a positive or a negative patient experience. ○ Antecedents may also include provider's role and the characteristics of the healthcare system. ○ Antecedents may also include a patient or family member experiencing some illness or health complaint that brought them to obtain care. ○ From the perspective of the institutional environment, antecedents may include an attempt to satisfy new policy standards, incentives for providers, or safety concerns. ○ Trust between the patient and care provider is viewed as a global attribute of the patient-provider relationship and is comprised of communication, competency, privacy, and satisfaction (Hall et al., 2011) Trust has been noted as a prerequisite to enhancing the patient experience and patient agency (Kraetschmer et al., 2004).

	<p>Consequences:</p> <ul style="list-style-type: none"> ○ Cost: Poor patient experience means decreased profitability for hospitals (Dempsey, Reilly, & Buhlman, 2017) ○ Trust: On the contrary, trust has been stated to be a barrier to the optimal relationship between the patient and healthcare provider. Stating patients should be "engaged information seekers, who shop carefully among competing providers, define their own needs, play an active role in their treatment and take responsibility for their treatment decisions" (Kraetschmer et al., 2004, p. 318). While this may seem like the ideal patient engagement and experience, there are many barriers to this reality. ○ The consequences of patient experience may include outcomes of care and patient satisfaction. ○ Consequences for outcomes include increased patient safety, reduced healthcare costs, and identification of best practices. ○ Consequences may also include treatment adherence and increased monetary gains for the institution.
<p>Step 8: Defining empirical referents. Empirical referents are classes or categories of actual phenomena demonstrating the occurrence of the concept itself (Walker & Avant 1995).</p>	<p>To define empirical referents, I will include articles which discuss patient experience measurement instruments. I will also examine the patient experience measurement tools and extract how they measured patient experience. Once all of the domains of patient experience have been extracted in a matrix table from the measurement tools and articles discussing patient experience instruments, the domains will be categorized into attributes. Patient experience instruments which will be analyzed to extract domains:</p> <ol style="list-style-type: none"> 1. HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems 2. QPP: Quality from the Patients' Perspective 3. QPPS: Quality from the Patients' Perspective Shortened 4. PPE-15: Picker Patient Experience Questionnaire 5. NHSIP: NHS Inpatient Survey 6. SIPES: Scottish Inpatient Patient Experience Survey 7. HKIEQ: Hong Kong Inpatient Experience Questionnaire 8. PEQ: Patient Experience Questionnaire 9. NORPEQ: Norwegian Experience Questionnaire 10. I-PAHC: Patient Experiences with Inpatient Care 11. PPQ: Patient Perception of Quality

Appendix B: CADTH PRESS Checklist

First Reviewer: Michael Boutet

Project: Patient Experience for concept analysis

Second Reviewer: Lindsey Sikora

Revised and adapted from: Sampson M, McGowan J, Lefebvre C, Grimshaw J, Moher D. Peer review of electronic search strategies. Ottawa: Canadian Agency for Drugs and Technologies in Health [in progress].

1. Translation:

Is the search question translated well into search concepts?

No revisions

Suggested revisions:

2. Operators:

Are there any mistakes in the use of Boolean or proximity operators?

No revisions

Suggested revisions:

3. Subject headings:

Are any important subject headings missing or have any irrelevant ones been included?

Consider whether exploded terms, subheading, major emphasis and other subject heading devices are used to the best advantage.

No revisions

Suggested revisions:

Even with a concept analysis, it's odd to not see subject headings in the search. I have put some suggested MeSH for the Medline search in the Additional Comments below.

4. Natural language:

Are any natural language terms, spelling variants, missing or have any irrelevant ones been included? Is truncation used optimally?

No revisions

Suggested revisions:

Please see Additional Comments for combinations of natural language, to include various truncations for all terms searched, which add to the current search strategy.

5. Spelling & syntax:

Does the search strategy have any spelling mistakes or system syntax errors or wrong line numbers?

No revisions

Suggested revisions:

Please see Additional Comments for combinations of natural language, to include various truncations for all terms searched, which add to the current search strategy.

6. Appropriate search filters:

Are the appropriate search filters being applied (e.g. systematic reviews, RCTs, guidelines, etc.)?

No revisions

Suggested revisions:

7. Limits:

Do any of the limits used seem unwarranted or are any potentially helpful limits missing (e.g. publication types, methodological filters, language, dates)?

- No revisions
- Suggested revisions:

8. Fields:

Are the appropriate fields being searched (i.e. title, abstract, registry number, etc.)?

- No revisions
- Suggested revisions:

9. Adapted databases:

Are all relevant databases being searched? Has the search strategy been adapted for each database?

- No revisions
- Suggested revisions:

I strongly suggest you adapt your other searches to reflect the inclusion of the subject headings below, as well as the combinations for the natural language (keywords). This is to ensure that you do not miss any relevant articles, as the term “patient experience” may have evolved over time. Also, when searching in PubMed with some of the articles from the references from the draft proposal Tanja provided, I pulled these MeSH from those titles, as well as the keywords.

10. Additional suggestions/comments:

Suggested search strategy for Medline:

Patient-Centered Care/
(patient adj3 experience*).tw.
(patient adj2 perspective*).tw.
(patient adj2 opinion*).tw.
(patient adj3 measure*).tw.
or/1-5

Adapted from the following study found in Tanja’s research proposal:

Beattie, M., Murphy, D. J., Atherton, I., & Lauder, W. (2015). Instruments to measure patient experience of healthcare quality in hospitals: a systematic review. *Systematic Reviews*, 4(1), 97. <http://doi.org/10.1186/s13643-015-0089-0>

I would then translate this search strategy into the other databases.

Appendix C: Search Term Examples

Term	Working Definition	Inclusion Example
“Patient Experience”	Subjective perception of the health care they received.	The patient felt supported throughout their stay.
“Patient and Family Experience”	The focus of care/attention on the patient’s and family member’s subjective perception on care they received.	What does the patient and their family think about the communication between the healthcare providers and them?
“Patient Reported Experience Measure”	Measuring the patient’s perceptions of their experience whilst receiving care”	What the patients thought about the process of care they received.
“Patient Reported Experience Measure”	Measuring the patient’s perception of the care they received.	What does the patient think about the cleanliness, timeliness, and staff?
“Patient Care Experience”	Patient’ subjective perception of care provided to them personally by a staff member.	“The coordinated effort of several providers before, during, and after surgery shapes patients’ care experience and comfort..”