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Creating a Healing Environment: Strategies Christian Nurses Use

Jane Bacon Pfeiffer

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LOMA LINDA UNIVERSITY
School of Nursing
in conjunction with the
Faculty of Graduate Studies

Creating a Healing Environment: Strategies Christian Nurses Use

by

Jane Bacon Pfeiffer

A Dissertation submitted in partial satisfaction of
the requirements for the degree
Doctor of Philosophy in Nursing

June 2014

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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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ABBREVIATIONS

GGT	Glaserian Grounded Theory
GT	Grounded Theory
OHE	Optimal Healing Environment
IHOS	International Hospital Outcomes Study
EBD	Evidenced-based Design
EHE	Enhancing the Healing Environment
WS-CAM	Whole Systems of Complementary and Alternative Medicine
MRI	Magnetic Resonance Imaging
UZI	Urban Zen Initiative
PICU	Pediatric Intensive Care Unit
NICU	Neonatal Intensive Care Unit
ICU	Intensive Care Unit
HHA	Healing Healthcare Model
HNM	Holistic Nursing Model
HES	Healthcare Environment Survey
CFS	Caring Factor Survey
PCU	Patient Care Unit
AICU	Adult Intensive Care Unit
TT	Therapeutic Touch
VIP	Very Important Person
PCA	Patient Care Attendant

ABSTRACT OF THE DISSERTATION

Creating a Healing Environment: Strategies Christian Nurses Use

by

Jane Bacon Pfeiffer

Doctor of Philosophy, Graduate Program in Nursing

Loma Linda University, June 2014

Dr. Patricia S. Jones, Chairperson

Nursing metaparadigm concepts of nurse, person, environment, and health are the conceptual building blocks which provide direction to nursing research and knowledge development (Fawcett & Desnato-Madeya, 2013). Interaction of person, nurse and environment facilitate optimal outcomes yet, there remains a need for research on the paradigm concept of environment and creation of a healing environment in particular. (Meleis, 2010).

The purpose of this study was to explore the strategies Christian nurses used to create a healing environment and enhance well-being for non-end-of-life, hospitalized patients from admission forward. Specific aims included identifying nurses' perspectives on (1) the strategies Christian nurses used to create a healing environment and enhance well-being, (2) the outcomes they perceived resulting from these strategies, and (3) the factors they regarded as either enhancing or inhibiting the creation of the healing environments. An additional aim was description of characteristics of nurses who created healing environments and enhanced well-being.

In this qualitative, Glaserian grounded theory (GGT) study, interview data were collected via a demographic "Information about You" sheet (see Appendix D) and semi-

structured interviews (see Appendix C for interview guide) of nurses (N = 15) until data saturation was reached. A criterion-based, purposive sample was recruited, and tape-recorded face-to-face interviews were transcribed verbatim, coded, and analyzed using constant comparative methods in consultation with a grounded theory expert.

“Charting the healing path” is the core category and consists of four phases: helping patients get better, fostering the healing environment, charting a healing path, and observing outcomes. Within this model are ten substantive categories of baseline assessment, being available, knowing as a unique individual, hearing immediate concerns, seeing from the patient and the nurse points of view, partnering with the patient, setting realistic goals, realizing best potential, and outcomes. See Figure 1 for a conceptual model.

The “charting the healing path” model informs development of the environment domain of nursing knowledge. Knowing the patient, the juncture of nurse and patient points of view, and the resultant nurse-patient partnership seek best potential outcomes to be realized incrementally during, and after, hospitalization.

CHAPTER ONE

INTRODUCTION TO THE STUDY

Creating a Healing Environment: Strategies Christian Nurses Use

From Florence Nightingale to the present, nurses have been concerned with the environment in the patient's recovery from illness and return to health. Specifically, nurses, and the broader health care community, are interested in what contributes to and what acts as a barrier to the healing of patients. Therefore, it is important to understand how nurses create a healing environment and enhance well-being of hospitalized patients.

Historically, Nightingale identified elements of nature essential in the healing process: adequate ventilation; sunshine; noise reduction; cleanliness, including daily soap and water baths for nurse and patient; and infection control procedures of hand washing prior to each patient contact (Nightingale, 1992; Pfetscher, 2010). In the progress of the past 150 years, hospitals now have policies against open windows due to patient safety concerns. Ironically, hospital ventilation systems have occasionally become the source of disease transmission, sick-building syndrome, or, at the least, a setting of inadequate ventilation (Sahlberg, Mi, & Norbäck, 2009; Straus, 2009). This is but one illustration of how progress in the name of healing can override the basics. Parallel to limiting the healing effects of nature within the hospital physical environment are the demands that technology often places on the basics of compassionate care in the process of healing. The resultant task-oriented approaches to care can easily lead to losing sight of a larger paradigm of caring characterized by touch, affirmation, presence, and their healing effects on the person (Brunner, 2009; Edvardsson, Sandman, & Rasmussen, 2003; Walker, 1994; Wood, 2007).

Nightingale capitalized on the patient's innate healing power by structuring the environment and influencing the character and knowledge of the nurse for healing interaction. Nightingale's own spiritual roots, and understanding of spirituality as an element of wholeness and healing, fostered an integrated care of the body and spirit (B. Dossey, 2010). For Nightingale, care of the body would likely demonstrate and reflect care of the spirit or soul.

Building on the work of Nightingale, nurse scholars in the mid-to-late twentieth century identified components of the burgeoning knowledge domains of nursing. Fawcett (1984) introduced a philosophical level of knowledge called the metaparadigm to further the work of theory, conceptual models, and frameworks developed within nursing. The original four metaparadigm concepts—man, society, health and nursing—were refined to person, health, environment, and nursing (Fawcett & Desnato-Madeya, 2013). These were designed to be “perspective neutral” (Alligood & Tomey, 2010, p. 45) and, therefore, able to be used within each theory or conceptual model of nursing. Discussion of the necessity and qualifications for a metaparadigm has not had universal acceptance or agreement within the profession (Cody, 1996; Meleis, 2007; Morse, 1996). Nonetheless, the metaparadigm concepts continue to give direction to a professional understanding of what nursing is, and what it is not, as well as frame theory and research for nursing.

Though not all nursing theorists have labeled the metaparadigm concepts explicitly, the particular perspective of each can be inferred from their writings. Environment is understood as encompassing relationships of significance, physical surroundings, the settings in which nursing occurs, as well as the broad political, social,

cultural, and economic forces affecting health in general (Fawcett & Desnato-Madeya, 2013). A healing atmosphere or environment for hospitalized patients is one which embraces the whole person and facilitates interaction of person, nurse and environment for optimal health outcomes (Nightingale, 1992; Walker, 1994). In support of the metaparadigm concepts being perspective neutral, it is important to recognize the influence of worldview on their use and application in nursing.

Whether rooted in theism, naturalism, or postmodern antirealism, a health care professional's worldview on health, healing, person, nursing, and environment shades the understanding of each one of the concepts explicitly or implicitly. It is impossible to look at the world outside of some kind of a worldview. As conflicting as different worldviews may be, worldview permeates and reaches all aspects or realms of the person (Moreland & Craig, 2003). Worldview shapes one's understanding, values, beliefs, and practices. These personal, life-orienting commitments will inevitably shape professional practice consistent with one's worldview (Sire, 2009). Regardless of the worldview held, the person plays a pivotal role in healing (though the degree to which the individual orchestrates the healing may be seen quite differently), and it is nursing's privilege to assist the person in his or her pursuit of health and healing (B. Dossey, 2010; O'Brien, 2014).

The Problem

From a metaparadigm perspective, environment is one of four central concepts in the domain of nursing knowledge (Fawcett, 1984). Applying this to nursing education, Fawcett (1984) gave definition to environment as "the surroundings and significant others that may facilitate or impede" (p. 226) the learner or the teacher role in knowledge

acquisition. Adapted to the hospital patient-centered setting, environment can be understood as the surroundings and significant others which facilitate or impede healing and well-being.

Recent focus on patient-centered care includes viewing the patient as full partner in the design of a path to health and well-being (Brady, 2011; McCance, McCormack, & Dewing, 2011; McCormack, Karlsson, Dewing, & Lerdal, 2010). This partnership automatically provokes and calls us to understand health, healing, and well-being as the goal, the best outcome possible, toward which nurses work. Environment, as a concept, has gained recognition from nursing theorists from widely differing perspectives (Benner, 1994; Benner & Wrubel, 1989; Meleis, 2007, 2010; Parse, 1993; Rogers, 1992; Watson, 1999) and from interdisciplinary academic and research groups (Findlay, Smith, Finch, & Loveless, 2006). Nursing research that describes “properties, components, and dimensions of environment that are healthy or that help in maintaining or changing health care outcomes” (Meleis, 2007, p. 477) will contribute to the knowledge base of this metaparadigm concept.

In addition to the theorists’ views of the environment, the interaction of the patient, the nurse, and the environment has more recently been seen from an outcomes-of-care perspective. The Institute of Medicine (IOM) (National Research Council, 2011) report calls nurses to function to the capacity of their educational preparation, taking the lead in making system-wide and organizational culture changes in addition to the direct care-giving role. To the degree that nurses embrace the challenge of shaping their professional environments (rather than sagging in them), nurses can be intentional about creating healing environments. Nurses, as the professionals most often present with the

patient, are continuously challenged to create and sustain, versus erect barriers to, an environment of healing. This study raises the question: how do nurses who are referred to as experts in care actually create a healing environment that enhances patient well-being? By exploring nurses' perspectives on creating healing environments, this study makes a contribution to the theoretical discussion at the interface of the metaparadigm concepts of nursing and environment. More specifically, this study reveals and informs how Christian nurses perceive the process and outcomes of creating a healing environment in the hospital.

Purpose and Aims of the Study

The purpose of this study is to explore how Christian nurses create a healing environment and enhance well-being for hospitalized, non-end-of-life patients from admission forward. Specific aims include gaining their perspectives on (1) the strategies they use to create a healing environment and enhance well-being, (2) the outcomes they perceive resulting from these strategies, and (3) the factors they regard as either promoting or acting as barriers to the creation of healing environments to enhance well-being. Additionally, this study describes the characteristics of Christian nurses who create healing environments.

Exploratory Questions

Five research questions are:

- 1) What strategies do Christian nurses use to create a healing environment to enhance a patient's well-being?
- 2) What outcomes does he or she perceive have resulted from these strategies?
- 3) What factors promote a healing environment?

- 4) What factors act as barriers to a healing environment?
- 5) What are the characteristics of Christian nurses who create healing environments and enhance well-being?

Significance of the Study

Significance for Nursing Practice

The significance of this study for nursing lies in the identification of strategies by Christian nurses to effectively create healing environments for patients to enhance their well-being. Furthermore, factors which either promote or act as barriers to the strategies nurses use are described, and the influence of these strategies on patient outcomes are also identified from the nurses' point of view. Second, this nurse-reported approach to creating a healing environment allows for comparison of published hospital administrator-reported approaches (see the discussion of Optimal Healing Environment studies in chapter two). Third, this study may offer a description of characteristics of self-identified Christian nurses who practice in faith-based hospitals and create healing environments, how they contribute to patient well-being, as well as how holistic healing environments affect nurse well-being. Narrowing the focus to Christian nurses in faith-based hospitals offers the nursing profession one view of creation of a healing environment where the nursing practice model and the hospital philosophy are jointly supportive of whole person care. Last, this study may give direction to future study of nurse-patient healing factors.

Significance for Theory

Significance for theory potentially includes three categories of knowledge development related to environment: developmental, systems and interaction realms of

knowledge (Fawcett & Desnato-Madeya, 2013). Additionally, the study offers identification and description of behaviors, sentiments, cues, symbols, and nurse strategies associated with nurses creating healing environments that enhance well-being in patients. Specifically, situation-specific behaviors and approaches Christian nurses use to create healing environments and enhance well-being will contribute to healing and health promotion aspects of nursing theory.

Overview of Remaining Chapters

Chapter two gives an overview of the metaparadigm concept of environment as seen in nursing theories and literature pertinent to the key concepts of healing environments. This overview involves research, literature reviews, the theory basis of research studies in nurses' creation of a healing environment, and gaps currently seen in the research literature.

Chapter three includes details of the research design as a qualitative grounded theory study, the procurement of a sample population, and a plan for the analysis. These details, of necessity, were clarified as analysis proceeded.

Chapter four presents the findings of the study with supporting data. Included in this chapter is a conceptual map of the "charting the healing path" model.

Chapter five discusses the relevance of the "charting the healing path" model in nursing. Limitations of this study, with recommendations for further study, are also presented.

CHAPTER TWO

THE RESEARCH LITERATURE

Rationale for the Literature Review

In an effort to foster healing at a wholistic (bio-psycho-social-spiritual) level of the human being and to describe that which contributes to a healing environment, parameters of the healing environment are reviewed and discussed (See the discussion of wholistic versus holistic as defined in Appendix A). First, a review of the metaparadigm concept of environment, as seen in nurse theorists' work, is presented. Second, concepts present in the healing environment literature are reviewed including optimal healing environments (OHE), design and structure, space, and organizational commitment to healing environment initiatives. Third, research studies peripheral to nursing, studies in which there is nursing involvement, and studies involving nurse perception are examined. The role of the nurse and the theory base in these studies are discussed, if present. Fourth, nursing practice models or theory-based models with philosophical components are presented. Last, the gap in the literature this study seeks to address is examined. Appendix A gives a list of *a priori* definitions which framed the study's conception and literature review. Appendix B contains the research grid with the search terms, the databases used, and the number of resultant articles accessed prior to the qualitative research.

Healing Environment and Well-being

In a review of nurse theorists' views of the metaparadigm concept *environment* as seen in Allgood and Tomey (2010) and Fawcett and Desnato-Madeya (2013), this author has identified three artificial perspectives for purposes of description. Although these

perspectives intersect some and merge in various theories, the three delineations can be helpful for viewing the concept of environment. The three groupings include: (a) the situation and setting of the nurse-patient interaction, (b) a spatial view of the environment combined with situational particulars, and (c) a context which asserts influence on the person or environment (sometimes interchangeable). Each of these lenses will be succinctly examined for relevance to the concept of interest, a healing environment. Additionally, a brief discussion of four nursing theorists, whose work can be compatible with a healing environment within a Christian worldview, follows.

Situation and Setting of the Nurse-patient Interaction

A number of theorists recognize both internal and external aspects of the patient and the setting comprising the environment. Examples include (1) Levine's Conservation Model (Levine, 1971; Schaefer, 2010), (2) King's Theory of Goal Attainment (King, 1981; Sieloff & Messmer, 2010), (3) Neuman's Systems Model (Freese & Lawson, 2010), and (4) Roy's Adaptation Model (Andrews & Roy, 1986). Others recognize the social aspect with social definition and attendant meanings; e.g. Benner in *Caring, Clinical Wisdom, and Ethics in Nursing Practice* (Benner, Tanner, & Chesla, 2009). Artinian (1991) in the Inter-System Model, Ray in the Theory of Bureaucratic Caring (Coffman, 2010), and Neuman in the Systems Model (Freese & Lawson, 2010) acknowledge system interaction and symbolism present in this situation/setting view of the environment.

A Spatial View Combined with Situational Particulars

A second grouping of theorists' views of the environment could be termed a spatial one with infusion of situational specifics. Nightingale emphasized nature-infused

spaces. Martinsen, as cited in Alvsvag (2010), describes space as including time, ambience, and power while the particulars require infusion of dignity to people in these spaces. Watson, as cited in Jesse (2010), in her later version of theory, writes of healing spaces combined with an earlier view of environment including physical, mental, societal, and spiritual dimensions. Orem's language does not specifically describe environment, but she wrote of space-time localization where change was impending as cited in Berbiglia & Banfield (2010). Kolcaba's description of the context in which comfort occurs is another example of the spatial view of environment with particulars always considered (Dowd, 2010; Kolcaba, 2006).

Context Which Asserts Influence on the Person or Environment

The last of the descriptive groupings gives credence to the many kinds of influence on the environment and would likely support, as Swanson, as cited in Wonjar (2010) does, the interchangeability of the metaparadigm concepts depending on the situation. Leininger's Culture Care Theory of Diversity and Universality speaks of the totality of environment, [its influences], and the experiences which give meaning to a person's response (Leininger, 1994, 1996). Boykin and Schoenhofer's Nursing as Caring theory emphasizes the relational focus and expression of place, space, time and relationship as constituting environment (Boykin, Schoenhofer, Baldwin, & McCarthy, 2005).

These three groupings are ways of viewing the environment present in theories of nursing. Since this study focuses on Christian nurses and strategies used to create a healing environment, the discussion now looks at ways that four theorists' works are compatible with environment from a Christian worldview.

Compatibility with a Christian Worldview

An explicitly Christian worldview includes a view of the person as a body-spirit unity reflecting and living in an open system of exchange between God, humans, and the environment (Shelly & Miller, 1999). This overview characterizes the human as a social and relational being with capacity to create and respond to self, others, God, and the environment (Hui, 1997b). Theories can be compatible with these parameters without being explicitly Christian in orientation. Four examples are given in the following discussion.

Two early nurse theorists congruent with a Christian worldview are Orlando and Travelbee. Orlando's (1961, 1990) Nursing Process Theory does not explicitly identify the patient as a spiritual being yet focuses on the nurse-patient relationship, its reciprocal nature, and acknowledges limitations and barriers within the environment that can disrupt the nurse-patient relationship. She emphasized the importance of validating nurse perceptions of patients' behavioral responses. Whether the patient can answer or not, it honors the patient as full partner in the ongoing nurse-patient relationship. Within a Christian worldview, the intrinsic value of a human being as free agent is affirmed. Therefore, a perspective on the nurse-patient relationship that honors the patient as autonomous partner, with unique challenges and needs, seems compatible with a Christian worldview.

Travelbee's (1966) Human-to-Human relationship model also focused on the nurse-patient relationship and the intrinsic value of the human. Chinn and Jacobs, as cited in O'Brien (2011), report Travelbee's description of illness as a spiritual, emotional and physical experience. Her stance, "Every human being has value and worth by nature

of his human-ness” (p. 32) is humanistic in orientation and supports the horizontal (human to human) caring encounter within nursing. The Christian worldview shares this value of the human and the caring relationship but grounds the intrinsic value and sense of relatedness to one another in being created in the image of God and being redeemed by God in Christ Jesus for relationship. This relationship involves both the human-to-human caring relationship and the divine-to-human caring relationship.

A third nursing theorist, Madeleine Leininger (1996), developed the Culture Care Theory of Diversity and Universality and the Sunrise Model of culturally integrated nursing care. Leininger describes care as a powerful humanizing force which incorporates the cultural knowledge of the patient and his or her community in the care given. This care includes the religious, political, economic and environmental context which constitutes this person and his or her perceptions and understandings of life and the surrounding world. She is known for her saying, “There can be no curing without caring, but caring can exist without curing” (p. 72). While all cultural care knowledge is relative to a specific culture under investigation, Leininger’s model allows for a Christian worldview as one cultural specific form and is, therefore, compatible with a Christian worldview.

A modern nurse theorist, Patricia Benner, along with multiple other nurse researchers, champions caring as essential to nursing. In her joint work on the Primacy of Caring (Benner & Wrubel, 1989), the human is described as a creature [implying a Creator] “of significance constituted by relationships, meanings, and memberships, in short, a creature of culture” (p. 52). Her phenomenological view of the person means the person is constituted by commitments of care and has both a situated freedom and a

situated possibility that promote choice and creativity in response to these commitments. Though Benner never positions herself as coming from a distinctly Christian perspective, her philosophy resonates deeply with a Christian worldview and can easily be understood from this perspective. Benner and Wrubel (1989) address the concept of environment directly as they describe the phenomenal body with its own embodied knowledge to overcome limitations of the environment. They contend that nurses who understand the phenomenal body (one ready to act with built-in understandings that often transcend illness and insult) and are aware of the meanings of the situation and the surroundings (environment) for the patient are adept at creating a healing environment.

Just as Nightingale (1992) understood that the human body has natural and spiritual healing capacity, if placed in an environment conducive to healing (Selanders, 2010; Timmins, 2011), today's nurses recognize promotion of positive patient outcomes and well-being as central to nursing. Thus, literature is now reviewed for that which explicates the relationship between nurse, patient, and environment for outcomes of healing and well-being. Reported below are results of a literature search done prior to the grounded theory research portion of the dissertation. See Appendix B for a grid of search terms, databases, years searched, and outcomes.

Optimal Healing Environments

Similar to Nightingale's (1992) focus on healing and well-being is the Optimal Healing Environment (OHE), a decade-old movement that has prioritized whole person care and the environment of salutogenesis (the process of healing) with health and healing as the outcome versus pathogenesis and treatment of disease (Jonas, Chez, Duffy, & Strand, 2003). Elements identified by the OHE research that stimulate healing include

“developing healing intention, experiencing personal wholeness, cultivating healing relationships, practicing healthy lifestyles, applying collaborative healthcare, creating healing organizations, and building healing space” (Findlay et al., 2006, p. 5; Horowitz, 2008). The Samueli Institute, a national non-profit institute supporting the study of healing worldwide, sponsored a large survey of OHEs with 55 out of 125 hospitals in the Midwest region of the United States responding. This prospective pilot study using a convenience sample ($N=55$) explored healing environment initiatives, their nature and prevalence, and evaluation of nursing care, collecting qualitative and quantitative data. Identified themes about current hospital practice were “(1) provision of holistic patient-centered nursing care at the bedside; (2) employer investment in self-care of staff; (3) use of physical space to improve the healthcare experience; and (4) incorporation of spirituality into the healthcare process” (Findlay et al., 2006). Additionally, qualitative data from this study affirmed many of the components listed above in the OHE framework. While these authors provide a substantive list of contributing elements of a healing environment, they do not provide a specific definition of holistic nursing, nor does it give nurses’ perspectives of what contributes to a healing environment.

In contrast to the OHE, the University of Pennsylvania led an International Hospital Outcomes Study (IHOS). Researchers Clarke and Aiken (2008) maintain that nurses in direct patient care (versus hospital administrators) would be the most accurate and reliable source of organizational, process, and nursing care attributes. The conclusion of this international study was that optimal management of nursing environments is central to attaining the best patient outcomes.

Design and Structure

An expanding body of literature focuses on the external physical environment of health care settings and their effect on the health and well-being of patients (Carpman & Grant, 1993; Charmel, Frampton, & Gilpin, 2003; Dijkstra, Peiterse, & Pruyn, 2006; Horsburgh, 1995; Schweitzer, Gilpin, & Frampton, 2004). Environmental factors such as music, scent, indoor foliage, color, and healing gardens can contribute to patient well-being and satisfaction (Geffen, 2004; Park, 2009; Raanaas, Patil, & Hartig, 2010; Soderback, Soderstrom, & Schalander, 2004; Van Rompay & Tanja-Dijkstra, 2010). The architectural structure of the built environment, using evidenced-based design (EBD) principles and its positive effects on the satisfaction of hospitalized patient's family and staff, support the use of architectural design decisions to foster healing environments (Foote & Schwartz, 2012; Kotzer, Zacharakis, Reynolds, & Beuning, 2011). In addition, there are nursing initiatives to influence the design of patient care units in a way that patients and staff perceive as healing environments (Guenther & Hall, 2007; Hunt, 2011; Kerfoot & Neumann, 1992; Waller & Masterson, 2010; Winslow & Jacobson, 1997). These initiatives stress nurse involvement from the beginning of building projects and design as well as unit specific plans that promote both the physical and psychological aspect of healing. These concepts, however, remain untested by research to validate which recommendations are effective in creating a healing environment.

Space Expressing Values

Research that validates creating space for physical, social, and spiritual healing is scant although the inter-professional discussion of designing spaces that heal is burgeoning. Horsburgh (1995) identifies four architectural qualities important to a

healing environment: spatial orientation, connection among people and people and the environment, scale of spaces, and symbolic meaning conveyed by structure and physical style. Each of these qualities has elements of space expressing values that, Winslow and Jacobson (1997) purport, patients and staff intuitively know and perceive. In a holistic nursing study reported below, each of the staff nurses validated space and place as impacting the process and outcome of patient healing (Lincoln & Johnson, 2009). Whether with dementia care (Hunt, 2011; Waller, 2012; Waller & Masterson, 2010), pediatrics and neonatal units (Altimier, 2004; Coughlin, Gibbins, & Hoath, 2009; Geller & Warren, 2004; Sherman-Bien, Malcarne, Roesch, Varni, & Katz, 2011), or cancer and palliative care (Block, Block, & Gyllrhaal, 2004; Gauthier, 2002; Rasmussen & Edvardsson, 2007), enhancing the environment in ways that communicate a welcoming, safe, and caring space improves a variety of levels of satisfaction, quality of care, and well-being for patients and staff. With the exception of Hunt (2011) and Waller's (2012) work, the authors are not clear about the balance between system-wide organizational commitments and nursing unit commitments to these outcomes, nor are there measurements to adequately assess the subjective and objective components of a healing environment. Nonetheless, these studies are necessary and important beginnings to the evidence-based practice of creating a healing environment. Gauthier's (Gauthier, 2002) and Rasmussen and Edvardsson's (2007) work provide beginning conceptual views and views of healing from the patients' perspectives.

Organizational Commitment to Patient and Staff Well-being

Research and inter-disciplinary dialogue validate that the health care organization must be involved in planning and sustaining the healing environment. In Great Britain

the nurse-led initiative Enhancing the Healing Environment (EHE) program became a model for subsequent government-funded “healing the environment” initiatives. Initially, the London phase of the program was funded by The King’s Fund (45 projects) (Enhancing the Healing Environment, 2012; Hunt, 2011; Waller, 2012; Waller & Masterson, 2010). Subsequently, funding has come directly from the Department of Health for initiatives in dementia, mental health, and palliative care (Waller, 2012).

In the United States, there are both regional and local health care organizations emphasizing holistic care practices. One such regional organization is Planetree, a not-for-profit consumer health organization whose goal is to humanize health care by implementing holistic care practices (Bishop & Griffin, 2006; Geary, 2003). Examples of local health care models include the Three Rivers Community Hospital, Grants Pass, Oregon (Thornton, 2005) and Project Pebbles (Geimer-Flanders, 2009), as seen in the North Hawaii Community Hospital. Each of these demonstrates institutional backing for holistic caring initiatives in which both the architectural design of healing spaces and the nursing practice model mirror the philosophy of the institution. Though the patient is central in these models, the nurse is actively involved in creating and sustaining nurturing, healing environments that affect a positive experience for patient, family(s), and staff.

Another local model connected to a larger regional model is the Partners in Caring philosophy in Banner Desert Medical Center, Mesa, Arizona (Durstun, 2006). In each of these United States examples, implementation of the particular model has increased patient and staff satisfaction as an outcome. In both work and healing environments, patient and staff satisfaction are related to a sense of well-being.

However, the particular action, skill, or attitude which contributes to this increase in satisfaction is not parsed and validated. Further research needs to identify specific nurse and system-wide initiatives and how they contribute to improved work and healing environments.

Thus far, the review of literature has focused on three categories of initiatives which exert influence on the environment of the hospitalized patient. These have been viewed from the perspective of nursing theory and at-large factors believed to contribute to a healing environment. These initiatives all seek to recover a focus on patient healing within the hospital environment. Optimal management of nursing environments, and the larger organizational commitment to patient and staff well-being, stand out as dominant in promoting a healing environment. Examination of the research studies focused on those which promote a healing environment, recovery of well-being, and the role of the nurse in that process follows.

Nursing Research and Literature Reviews

Studies peripheral to nursing, studies with nursing involvement, and studies that detail nurse perception are discussed below. These research studies and literature reviews pertinent to creating a healing environment, accessed under the *healing environment, well-being, nursing research and nurse perspective* search terms are reviewed below. The role of the nurse and the theory of nursing practice are also noted if included in the article (See Appendix B for research grid).

Studies Peripheral to Nursing

Studies peripheral to nursing include areas that interface with nursing or have ability to measure and help define areas of further study. One of these studies is a

concept paper presenting a measure developed for process-oriented research (Howerter, Hollenstein, Boon, Niemeyer, & Brule, 2012). This Canadian and U.S. research team has taken a measure originally applied in developmental psychology and adapted it for use in whole systems of complementary and alternative health care (WS-CAM) settings to capture emergent holistic patterns of change in clinical situations. Two case studies are given: (1) the interpersonal emergent behavioral systems chart the dynamics of patient-practitioner interaction, and (2) the intrapersonal emergent behavioral systems examine the process of change within the person over time. The role of the nurse is not addressed in this study, nor is the theory or philosophy supporting it. However, the WS-CAM therapies mentioned are those from a holistic, energy-based perspective, specifically traditional Chinese medicine, classic homeopathy, and Ayurveda. Philosophically, these therapies stand in contrast to a theistic, Christian view of healing and well-being.

Another study on the periphery of nursing is the impact imaging room environment study (Quan, Joseph, & Ensign, 2012). An anonymous questionnaire was administered to compare patient ($n = 83$ for intervention group, 73 for control group) and staff ($n = 28$ for intervention groups, 26 for control group) perceptions of the physical environment of the magnetic resonance imaging (MRI) experience. While staff perceptions were not significantly altered, patients reported more pleasantness ($p = .001$) and environmental control ($p = .04$) in the intervention group rooms in contrast to the comparison rooms. Patient perceptions were not statistically significant in quality of patient areas, safety, and acoustics. The significant findings addressed environmental issues that contribute to patient satisfaction when receiving MRI's. This study shows

modest improvement of environmental measures without including the significant others, that is, without including the perception of the nurses or imaging staff.

A third study was a literature review with data from twelve Japanese hospitals (Suzuki, 2010). Twelve hospital databases with 1235 photographs and descriptive data were reviewed in order to categorize areas of grand design of the care environment. Four areas emerged as important to the care environment: smell, lighting, sound, and a natural environment and healing space where the individual could feel at ease. These data came from chart review versus from nurse or patient interviews. Thus, it is unclear whose interpretation is reflected in the data analysis, and outcomes have not been validated by further research.

Another theory-based approach to holistic care and well-being, peripheral to but embracing nursing, is that of quantum mechanics and complexity of design. This is perhaps best depicted in the work of the HeartMath research institute. This group of researchers, led by physiologist Rollin McCraty, believes coherence is key to harmony and health and “applies to every possible domain from the invisible, subatomic quantum level to the farthest galaxies and everything in between” (L. Dossey, 2010). Dossey (2010) cautions bodily coherence and coherence of thought are not always healthy, and gives multiple examples of coherence as rigidity, dysfunction, disease, and aging. In these instances, chaos is exemplary of health and healthy behaviors. Nonetheless, The HeartMath research has validated, via measure of heart rate variability, that the heart is a source of intelligence, especially in generating and sustaining positive emotions. “These findings suggest that self-regulated heart techniques can be used for entrainment of other bodily sources of intelligence, and regulation of autonomic-mediated stress responses.

These discoveries offer a plethora of health, life style, and spiritual applications”
(Pfeiffer, 2010, p. 2).

The relational health-promotion aspects of communication within families was addressed in Benzein, Hagberg & Saveman’s (2008) paper on theoretical assumptions and applications of family-centered care. This university-based faculty and research staff practice receives any family of persons over the age of 18 without cost to intervene on promoting the family and nurse as collaborators in problem solving. No statistics are given; only the parameters of practice including “unusually appropriate questions,” reflections, and examples of how termination and closure are handled (Benzein et al., 2008, p. 112). This co-creating partnership encourages family members to see themselves as the expert in solving their family problems and develops expertise in members seeing themselves as a family rich in internal healing resources for ongoing family life. Both the HeartMath and faculty-staff family-centered care described above depict the power inherent in the human being. Research that isolates the power of the human heart measured as heart rate variability has yet to be correlated with nurse-patient-environment interaction.

A case study of one spiritual site, St. Anne de Beaupre, Quebec, Canada (Williams, 2010) illustrates the therapeutic landscape movement and its interface with health and healing. Williams (2010)utilized participant observation (though he eventually decided to forego interviews in order to promote, rather than violate, privacy of other pilgrims), documents published about the shrine, multiple conversations with a key informant (a brother on the grounds of the site), and extensive field notes for data gathering and analysis. His findings regarding space include sacred healing space and its

stillness can facilitate the health-enhancing effect of retreat and solitude. He suggests that spiritual pilgrimage sites offer a healing space to retreat from the demands of daily life and experience “affective spaces of peace, rest and contemplation, contributing to an atmosphere that offered healing and health” (Williams, 2010, p. 1639). The health-enhancing effect of retreat and solitude remain without subjective or objective measure in a nursing environment.

These studies demonstrate limited validation of space and architectural design elements as well as relational health-promotion capacities inherent in the person-environment interaction. However, nursing is absent from these studies. Thus, two categories of nursing involvement are now explored. One includes nursing and other health care staff participation; the second focuses on nurse perception of care and the work environment. Both of these perception categories are significant for the patient-nurse-environment interaction effects on creating a healing environment.

Nursing Involvement

Nursing involvement is seen in Kligler et al.’s (2011) use of a nonrandomized, nonequivalent group method to study cost savings on an inpatient oncology unit utilizing an integrative medicine approach. Sample size of the baseline group ($n = 85$) at Beth Israel Medical Center before implementation of the Urban Zen Initiative (UZI) was compared with the intervention group ($n = 72$) after the UZI was in place. The UZI integrated yoga therapy, holistic nursing practice, and a “healing environment” into routine inpatient oncology care. Length of stay, total medication costs, and cost of as-needed medication (prn medications) were compared for both groups. While there was no significant decrease in length of hospital stay, there were significant decreases in

amount of total and prn medication costs. The entire nursing staff, nurse managers, staff nurses, and nurse aides were trained in holistic nursing techniques of relaxation therapies, imagery and visualization techniques, and aromatherapy. Healing environment principles included remodeling of the physical space to include creation of a healing sanctuary for meditation, yoga practice, quiet visiting areas for patients, quiet space for staff, and color and lighting changes for the unit as a whole. One other element that could be considered a part of the healing environment was creation of a “patient navigator” position “to facilitate a smooth and efficient process of care” (Kligler et al., 2011, p. 780). While this study illustrates the interaction of holistic nursing care and a healing environment on reduction in the use of medication, components are not specifically isolated to know which contribute to patient well-being measures.

Kotzer et al. (2011) administered a pre-post descriptive survey to all nursing, social work, therapy staff, and families on selected units of The Children’s Hospital of Denver, Colorado. The survey measured patient, family, and staff satisfaction scores before and after moving to a new facility on the following units: PICU, NICU, the cardiac ICU, clinical research center, medical/surgical units, and the oncology/hematology/bone marrow transplant unit. Comparison of the old hospital with a new, state-of-the-art pediatric hospital allowed researchers to evaluate the specific aims as follows: “1. Measure family and staff satisfaction with light, noise, temperature, aesthetics, and amenities. 2. Evaluate staff and family perceptions of safety, security, and privacy” (p. 65). Each question of the Staff Evaluation of the Built Environment (SEBE) and Family Evaluation of the Built Environment (FEBE) scale was answered twice: “once for satisfaction [on a five-point Likert scale] and once for importance [rated either

low or high]” (pp. 67-68). Staff satisfaction scores differed for nursing and therapy staff with statistically significant improvements ($p = < .05$) in all but 2 or 3 of the fifteen subscales for nursing. Therapy staff results varied more with fewer subscale satisfaction increases. The research team attributed this variation to therapy staff being frequently assigned patients on multiple units and, therefore, not being familiar with specific locations (storage, soap dispensers, proximity, etc.) which contributes to a sense of belonging and efficiency. Family satisfaction increased significantly on all subscales ($p < .01$), “especially for natural light, quiet space, parking, and the child’s room as a healing environment” (2011, p. 60).

The role of the nurse was not examined in this study, but several of the subscales were related to nursing interaction with the patient via the built environment, e.g. charting area, layout of the patient room, writing surfaces, comfort/appeal, break room, and proximities. Therefore, one can conclude the built environment’s effects on patient, family, and nurse satisfaction could potentially be predictors of well-being and possible measures of the healing environment. This study provides valuable background information on the components of the built environment which facilitates contact with the nurse. It does not address the role of nursing or the interaction of the two in creating a healing environment.

Vaajoki, Pietila, Kankkuenen, and Vehvilainen-Julkunen’s (2011) study on effects of listening to music on pain intensity and pain distress after major abdominal surgery suggests music intervention is an adjunct to other pain relief methods. The nurse researcher in this prospective clinical study collected data on two parallel groups: $n = 83$ for the music group and $n = 85$ for the control group (size based on power analysis of

80%). Patient's pain intensity and pain distress during bed rest, deep breathing and in shifting position were assessed. The visual analogue scale (VAS) assessment was done in the evening of the first post-op day, three times during the second post-op day, and once on the third post-op day. Findings included significantly lower pain intensity and distress during bed rest, deep breathing, and shifting position, on day two. No significant differences were found on day three related to long-term music use between the control and music group. As demonstrated by this study, assisting the patient with accessing the MP3 player and pre-loaded choice of music could be considered an adjunct, non-pharmacological pain relief method. This finding, however, does not require nursing skill and is a strategy that any person competent with MP3 technology could use to assist the patient.

The "Hospital-Based Spirituality Initiative: Creating Healing Environments" project was a collaborative effort between the George Washington Institute for Spirituality and Health and the Supportive Care Coalition: Pursuing Excellence in Palliative Care (Puchalski & McSkimming, 2006). A physician and a doctorally-prepared nurse team led this initiative to infuse spiritual care into all care given to patients, family, and staff. Five faith-based and two secular hospitals volunteered to participate in this pilot project. Each selected one clinical unit in which the initiative was tested. Core to the program was each hospital developing a location-specific approach designed to foster all stakeholders taking ownership and commitment to the training, implementation, and evaluation processes used. These included training in a person-centered approach to care, use of the specific spiritual assessment tool (Faith & Belief, Importance, Community, and Address in Care--FICA), and acknowledgement of their

role in this spiritual care giving. A primary value communicated during the training was the importance of all staff being essential and integrated into the healing environment. Patients and caregivers were surveyed at the beginning of the initiative and at three months, six months, and one year after the initial survey. The two authors and three other experts then evaluated the surveys and narratives for attitudes, stress level, satisfaction, trust in providers, and staff vacancy and turnover rates. Indicators of success reported include positive work culture and stronger sense of teamwork and community, improved interdisciplinary relationships in pilot units, fewer sick days, and manager-perceived staff satisfaction improvement. This spirituality initiative embodied the organizational commitment to demonstrate respect for patients, family, and caregivers. However, there are no statistical data given to critically evaluate the indicators of success, the organizational commitment, or the quality of the project evaluation.

With the exception of the Hospital Based Spirituality Initiative, these studies of health care staff participation remain peripheral to the role of the nurse in creating a healing environment. The exception fostered stakeholder ownership (nurses and all staff) and commitment as important elements of integration of spirituality in a person-centered approach to care as a primary organizational strategy for healing. This Spiritual Initiative is also consistent with a theistic, Christian worldview.

Nurse Perceptions

Nurse perceptions refer to how the nurse sees the issue or concern being addressed. Lincoln and Johnson (2009) conducted a study of staff nurse perceptions of a healing environment following a survey by the Holistic Practice Council within the same Minnesota hospital. They used a qualitative, multiple interview-based method. This

small ($N = 7$) study represented 30% of the staff from a diverse 18-bed medical surgical unit. An individual and two group interviews were recorded and transcribed. After the third session, a narrative summary was given with participant evaluation of the summary encouraged. The study began by asking, “What is the nature of a healing environment that supports holistic nursing from your point of view?” (p. 185). Findings were organized around realms of influence and the essences of the nature of a healing environment. Realms of influence include the extra-personal, interpersonal or intrapersonal categories while essences are listed as context, connections and calling.

The specific comments and conclusions were related to the healing healthcare model (HHA) of the local hospital, in concert with the OHE model discussed earlier and the holistic nursing model (HNM) supported by the American Holistic Nurses Association (AHNA). Nurse perceptions reinforced expected principles of the larger organization and validated the local hospital’s HHA. The authors discuss the nurse healer role as the means of access to “meaning and purpose in the practice of holistic nursing” and state “deep conscious relationship is the conduit to the essences of a healing environment” (p. 190).

Considering the two models (HHA and HNM) used for training of nurses, it is not surprising the outcomes reinforce the models. This study offers the categories of nurse healer role and deep conscious relationship for future studies of holistic nursing practice models. These categories may also be found in other nurse practice models. Therefore, research which connects these factors to creating a healing environment is important for all contexts of nursing.

A second nurse perception study included nurse and patient perceptions of the profile of a nurse effective in caring (Persky, Nelson, Watson, & Bent, 2008). Watson's Theory of Caring and Caritas model, participatory action research (PAR), and two psychometric measures were used to evaluate caring and work environment conditions from nurses' and patients' perspectives (N = 85 nurse-patient dyads). The Healthcare Environment Survey (HES) was completed by nurses, and the Caring Factor Survey (CFS) was administered to patients prior to implementation of the Relationship Based Care (RBC) delivery model at New York-Presbyterian Hospital/Columbia University Medical Center. Correlations using Pearson's (*r*) identified congruence of nurse and patient perception of caring behaviors and patient scoring of nurses perceived as most caring, by using *t* tests and analysis of variance. The authors postulated that the surprise finding of a negative correlation of every variable in the HES with the CFS may be explained by an incongruence between the demands of the healthcare environment and the values and goals of caring. For example, nurses perceived as most caring by patients were found to have the most frustration with "every work environment variable measured, especially workload" (Persky et al., 2008, p. 18). Future study is planned to reassess these findings and further validate the importance of caring in healing outcomes for patients.

This study is significant for understanding nurse and patient perspectives on the interaction of nurse-patient-environment factors and outcomes. The HES did name four system-wide components and organizational commitments involved in caring and work environment conditions from the nurses' perspective: executive leadership, learning opportunities, organizational rewards, and pride in the organization. Definition of each

of these was lacking, and the role of each in creating a caring-healing environment was not discussed. This study relates to the role of the nurse in making system-wide and organizational culture changes, as well as the direct care-giver role in creating a healing environment.

A non-randomized, controlled trial of a quiet-time intervention for patients in acute care was implemented on acute orthopedic wards of two major urban public hospitals in Brisbane, Australia (Gardner, Collins, Osborne, Henderson, & Eastwood, 2009). Four measures were used to determine noise levels, inpatients' rest and sleep behavior, and well-being. The study also investigated "the impact of the intervention on patients', visitors' and health professionals' satisfaction, and organizational [*sic*] functioning" (Gardner et al., 2009, p. 778). Strongly significant correlations were found between noise level and sleep ($r = -0.704, p < 0.01$) and awake ($r = 0.627, p = 0.01$) patterns in the experimental group while there were significant but weaker correlations ($r = 0.243, p < 0.05$) between noise level and awake patterns in the control group. Patients in the experimental group were twice as likely to sleep during the afternoon quiet time period, 2 to 4 p.m., as patients in the control group. Researchers concluded noise control and a scheduled quiet time can be considered a therapeutic, evidence-based strategy available for nurses to initiate within the system of care, at least on selected hospital units.

Findings did not support significance in relationship between noise levels, overall sleep status, and improved health outcomes for patients on the experimental units. One aspect of this limitation was related to a 15-25% rate of non-response on post discharge return of survey and other measures. A satisfaction survey was administered to patients,

family, and staff on the experimental units and yielded an overall indication of support for this quiet time period intervention and positive outcomes. Nursing staff were significantly more positive about the impact of the quiet time intervention on their clinical work and visitor access, whereas other allied health staff expressed more negative impact on their clinical work and schedule by the quiet time intervention.

A second environmental noise study sought to identify noise sources and implement noise reduction interventions at two Mayo Clinic Hospitals (Dube et al., 2008). This mixed methods study expanded a previous methodology used on one patient care unit (PCU) of one system hospital. A convenience sample of $n = 30$ patients from each of the total 55 PCU's ($N = 1650$) in the two hospitals comprised the patient population. The first of six specific study aims illustrates how nurse's perceptions are involved in this study: "identify the time of day and noises that were most bothersome in the hospital environment as reported by patients, nursing staff, and nursing leadership" (Dube et al., 2008, p. 217). Both patient and staff surveys used a five-point Likert scale, rating noise from very quiet to very loud, with four separate time period choices given to select the loudest period of the day. Pre-intervention and six month post-intervention surveys were collected with each unit selecting at least one noise reduction intervention for implementation and testing. Patient surveys were pen and pencil. Staff surveys were email surveys. Staff and patients agreed on morning as the most bothersome time and voices as the most bothersome type of noise. Other matched intervention and noise related outcomes are too numerous to list, but support the evidenced-based practice of noise reduction contributing to patient and nurse satisfaction and well-being in the hospital environment. No theory or practice philosophy was listed in this article. Both of

the above noise studies validate noise reduction as one possible nurse strategy for creating a healing environment, and that unit, or system-wide, policy would be needed for such intervention to be effective.

Another study of nurse perceptions of the work environment is reported by Broyles et al. (2008). A planned move into newly expanded and renovated adult intensive care units (AICU) was combined with a move toward a patient-centered care focus for this Tennessee hospital. The “Innovative Solutions” study hypothesis was that RN’s would have positive perceptions of the new work and healing environment. A convenience sample of registered nurses (RN’s), working all shifts, was obtained and surveyed pre-move ($n = 36$) and post-move ($n = 40$) for three focus areas: physical environment, interpersonal issues, and intrapersonal concerns. Though many of the enhancements made in the physical environments came from RN’s suggestions, findings revealed nurses did not perceive improvements or renovations as contributing to a better healing or working environment ($p = .04$). Additionally, “nurses perceived more stress related to technology and equipment within the new AICU ($p = .02$), and interpersonal relationships were perceived as being more stressful in the new environment ($p = .02$)” (p. 184). Possible sources of lack of positive results include the time needed to acclimate to change in systems, physical environment and new technologies, and lack of pairing in all pre- and post-survey participants. Only 20 of the RN’s participated in both surveys, and the surveys were given five months apart, whereas researchers stated 9 to 12 months might be a more reasonable period to decrease the change factors and see positive response in the RN’s work and healing environment.

Nurse as innovator and healer are two of the roles implied though not directly mentioned. Watson's Theory of Human Care and Donabedian's trilogy of quality care—structure, process, and outcomes—gave the theoretical underpinnings for this study. This study highlights the timing and readiness for change factors for the nurse and for measurement of these in units or hospital systems undergoing change. In contrast, the qualitative interviews of nurses on units not undergoing major system changes need to identify if there are particular changes affecting individual nurses as factors to be considered when healing environment research is conducted.

One last nurse perception study is the feasibility of using Therapeutic Touch (TT) in the operative environment with patients undergoing cerebral angiography (Madrid, Barrett, & Winstead-Fry, 2010). This randomized single-blind study, $n = 20$ control and 20 experimental patients, collected blood pressure, heart rate, and respiration immediately before, during, and after the procedure. A protocol was developed and implemented with no significant findings from the TT intervention. The nurse perspective would indicate TT in this population as practiced here was not an effective strategy for creating a healing environment.

Significant findings from the nurse perception studies for the patient-nurse-environment interaction effects on creating a healing environment include (1) a deep, conscious relationship state of connection with the patient as essential to a healing environment (Lincoln & Johnson, 2009), (2) the need for nursing values or philosophy and the organizational values and/or philosophy to be aligned and mutually supportive of person-centered care (Persky et al., 2008), (3) the value of quiet as essential for patient rest periods (Dube et al., 2008; Gardner et al., 2009), and (4) the importance of timing

and readiness for any change in structure, process or outcomes initiatives related to work and healing environment (Broyles et al., 2008).

Theory- or Practice-based Models

This section discusses the philosophical or theoretical basis of research and papers pertinent to creation of a healing environment. Two commonly used theorists, Martha Rogers and Jean Watson, are not congruent with a theistic, Christian worldview. Several examples of application of these theories are explored in greater depth below for relevant findings, which could be applied in a Christian approach to creation of a healing environment. This discussion is then followed with the philosophical underpinnings for the work of nurses creating a healing environment and enhancing well-being in hospitalized patients.

Theory-based Models

Theory-based models include Rasmussen & Evardsson's (2007) concept synthesis and derivation. This work utilized four published studies to create a preliminary conceptual framework for "atmosphere" and "at-homeness" (pp. 119-121) descriptive of the influence of environments in palliative care. They found Rogers' Science of Unitary Human Beings helpful in transposing concepts extracted from their previous research to the development of an emerging framework. In particular, Rogers' concepts of the unified interrelationship between person and environment, as an "irreducible and indivisible whole in constant interchange of energy ... integrality, interrelation, and mutuality" (p. 122) were similar to their concept of "atmosphere." Their data suggested the term "atmosphere" which they further developed, rather than Rogers' concept of the environmental energy field, as discernible but not directly observable yet manifest in a

field pattern. Interview examples are given which illustrate the embodied feeling or sense of the atmosphere as one of hospitality, safety, and “everydayness” (p. 123). From the recognition and synthesis of atmosphere as expressive of the pervasive environmental influence, they further delineated this influence in palliative care as one that supports or hinders experiences of “at-homeness.” Their data express “the indivisibility of the physical, social and symbolic qualities of the atmosphere” (p. 123) in the care given and received within hospice, oncology, medicine and geriatric settings. As evidenced in this study, Rogers’ Science of Unitary Human Beings is infused with holistic, energy-based theory and supports the development of corresponding holistic, energy-based practice and concept development. This study conceptualizes expression of “at-homeness” as a factor that promotes a healing environment within palliative care. This may or may not be present for hospitalized, non-end-of-life care patients. The “at-homeness” concept and the atmosphere of hospitality, safety and everydayness are descriptors consistent with a Christian worldview of “welcome one another as Christ Jesus has welcomed you, for the glory of God” (Rom 15:7).

Rogers’ Science of Unitary Human Beings is the guiding framework for Madrid, et al.’s (2010) application of TT to the out-patient operative setting. The authors quote the developer of TT, Kreiger, as saying TT is the clinical [practicum] for Rogers’ theory. Rogers’ description of health as the interaction between the human and the environment is the basis for energy pattern manifestations. The role of the practitioner is to direct and redirect this patterning for maximum experience of health. The pattern manifestations chosen for outcome measures in this study are the rhythm patterns of blood pressure, pulse, and respirations. The practitioner’s role is to assess and manipulate the patient’s

entire energy field in the midst of the larger energy field of the operating suite. As evidenced above, Rogers' Science of Unitary Human Beings, infused with holistic, energy-based theory, supports the development of corresponding holistic, energy-based practice and protocol for TT.

In contrast to Rogers' energy-based theory is the wholistic nursing approach in which touch is understood as a powerful tool for human-to-human communication. Here, touch communicates values of presence and care rather than energy field transmission.

Another theorist used in nursing practice and theory-based work is Watson and the Theory of Human Caring. In Persky et al.'s (2008) study to create a profile of a nurse effective in caring within Watson's Caritas framework, the humanistic relationship between patient and nurse is emphasized. The love and care demonstrated in this person-to-person relationship and the work environment in which this love and care occurs are the focus of this study. The explicitly humanistic relationship does not leave out the spiritual dimension, but it does not acknowledge God as the ultimate source of love and care. Therefore, the spirituality present in the caring profile of nurses practicing in Watson's Caritas will offer a humanistic-based love and care. The Health Environment Survey (HES) measured what factors would cause nurses to leave or stay at their jobs, and what creates the most stress for the nurse. The HES showed an inverse relationship with the patient-reported Caring Factor Survey (CFS) data. That is, the nurses the patients perceived as most caring were the ones who reported the greatest work environment frustration and dissatisfaction.

A second study utilizing Watson's Caritas framework is that of Broyles et al. (2008) Innovative Solutions study which measured the nurses' perception of the work

environment before and after changes were made in the adult intensive care units within one hospital. Authors cite the crucial caring role of the nurse and the relationship with the patient as the central theoretical components of the research. In addition, a quote from Watson's Theory of Human Caring is used to describe the relationship between the caring process and the healing environment. "Using the *caritas* processes, nurses can create healing environments at all levels of care, be authentically present, and assist with basic needs with intentional caring consciousness" (Broyles et al., 2008, p. 181). Here, the terminology of holistic nursing theory is present: intentional caring or intentionality, healing environments, authentically present, and caring consciousness. Each of these descriptors emphasizes the person-to-person relationship, whether from a monistic, theistic, or humanistic perspective (Pesut, 2008). Thus, both studies using Watson's *Caritas* framework will serve as comparison data for the current study. Will Christian nurses emphasize the person-to-person relationship as primary in creating a healing environment or will they give voice to both the Divine-to-human and the human-to-human reality of creating a healing environment?

Philosophical and Theoretical Perspectives

The monistic, theistic and humanistic terms bring us to the intersection of philosophy and science. This intersection helps frame the question asked as well the approach to answering the question. In this study, the intersection of the nurse and patient's worldviews frame the research question: "What strategies do Christian nurses use to create a healing environment to enhance well-being in hospitalized, non-end-of-life patients?" This worldview and philosophy discussion includes comparisons of the holistic and wholistic views of the "nurse as healer" role, distinctive characteristics of

philosophy and science views on healing and well-being, and conclude with a Christian view of health and well-being, and healing.

Nurse as Healer

Nurse as healer is a concept embedded in care and caring as the fundamental currency of nursing (O'Brien, 2014). Wholistic care acknowledges healing power located in partnership with a personal creator God who extends healing love and power to all, nurse and patient alike (O'Brien, 2014; Shelly & Miller, 1999; Willard, 2002). Nurses have the opportunity to assess the person's understanding of spiritual relationship and, when appropriate, offer connection or reconnection with a personal God as a resource for healing and well-being. Holistic care considers that the locus of control for healing lies within the patient (Bolles & Maley, 2004; Erickson, 2007; Mount, 2003; Watson, 2001).

Although healing can occur apart from the nurse-patient relationship, most often this human presence and spirit-to-spirit connection are key factors in creating a healing environment. Both energy-based practices of healing and Judeo-Christian, God-centered healing practices are believed to share a common value of the glory (the beauty, power, and dignity) of the human person. The difference between these two approaches resides in the source of this glory, whether it is the human itself or a personal creator God.

Likewise, the locus of control is nuanced differently. In the holistic healing paradigm the locus of control is within the patient, and the nurse aligns her energy field with that of the patient to effect positive change. In the wholistic paradigm the locus of control is a unidirectional one: A personal creator God is the source of all life and healing. The human is the recipient of this healing power and love. The Christian nurse has the privilege of joining this Divine-human encounter via assessment of patient

preferences and priorities and has the potential to bring God near, to be an instrument of God's love and power (Van Dover & Pfeiffer, 2007).

In either form, holistic or wholistic care, access to this innate power for healing comes from God as the patient interacts with the nurse and is released in the context of caring and healing (Shelly & Miller, 1999). Nightingale's (1992) emphasis on principles of a healing environment, and the inner spiritual resources of the patient, a philosophy of whole person care, and nurse as healer work together to facilitate the healing of patients (O'Brien, 2014; Selanders, 2010; Swanson & Wonjar, 2004). Citing Kreitzer and Ditsch (2003), Swanson and Wonjar (2004) describe the benefit of a "caring, healing, integrative approach to health care..." (p. S-43), leading to the wholeness and well-being of the nurse and the patient (Bolles & Maley, 2004; Watson, 1999). Healing is a concept present in Watson's (1999) artistic domain of her transpersonal, ontological, caring-healing model of nursing. It is also present in Swanson's (1991, 1993) theory of caring which emphasizes the well-being of the nurse while she facilitates a healing environment for the patient. Erickson (2007) understands the interaction of nurse and patient as creating a caring-healing energy field. She quotes Waters and Daubenmire who stated, "the essence of nursing lies in creating a healing environment and in engaging the patient's consciousness in the healing process" (p. 155). In the literature, caring and healing are parallel integrative concepts that often cannot be separated. Both contribute to nurses facilitating a healing environment in which the patient, and frequently the nurse, can move toward well-being.

In an overview of energy healers (Levin includes contemporary Christian healers in this overview) and what they do, Levin (2011) concludes, "it is exceedingly difficult to

identify universal core principles of theory or practice that underlie the work of healers” (2011). While he forthrightly asserts energy-based healing as his thesis and stance, the participants in this overview include Christians, and the conclusions drawn are also characteristic of a Christian, The five themes he identified are the issues phrased as questions, i.e.

- (1) [who or what] is the source of healing and the pathway by which it is transmitted to the client, . . .
- (2) Just what it is that is being transmitted or channeled or worked with by the healer and client? Is it energy? Is it something else? . . .
- (5) What is required of the client in order to receive healing? .

However difficult the identification of core principles may be, there is solid consensus concerning what matters for healers and healing: focus, compassion and intention. Backing this assertion is the Institute of Noetic Sciences’ (IONS) 125 pages of over 1,500 studies and reviews “on the physical and psychological correlates of meditative states of consciousness” (Levin, 2011, p. 22). The conclusion: possess these three heart attitudes (focus, compassion, and intention) and, regardless of the training system, philosophical stance, or method of healing, the road to becoming a healer is clearly in view. Heart attitudes, however, are not clear empiric data and are difficult to measure.

Philosophical and Theoretical Assumptions

Because creation of a healing environment involves both the observable (empiric) and non-observable (philosophic) aspects of reality, it is essential to clarify what role each plays in this study. Data documenting strategies nurses use to create a healing environment are prioritized in this study rather than a study of ideas about a healing environment and well-being. Thus, the study is primarily a scientific qualitative study

versus a philosophic inquiry (Pesut & Johnson, 2008). Being a qualitative scientific study does not mean nurses will not give voice to their beliefs and values in the processes of naming and describing strategies they use to create a healing environment and enhance well-being. Because all persons have beliefs and values, the description of these and/or characteristics of Christian nurses in this study could form a secondary thread of philosophical research. The primary focus, however, will be the processes and strategies Christian nurses use to create a healing environment.

Using qualitative methodology implies admission of both the observable and the subjective, non-observable as data—linguistic data in the form of verbatim interviews, in particular. Sandelowski (; 1993; 1998) and (personal communication, February 15, 2013) describes the role of theory in grounded theory research as a sensitizing framework. This framework may be useful in the early development of method and study design, and later in data analysis. Glaser (1998) is insistent that the researcher come to data analysis in grounded theory with no theoretical framework. Thus, there are no preconceived notions of the central concern of the participants; discovery of this central concern is the focus of the research (Cone, 2006; Glaser, 1998). Sandelowski (1998) affirms that the “researcher’s theoretical reformulation of the data” (p. 381) occurs in the analysis and write-up, and the expected outcome is the theory itself. If the theory no longer fits, it should be expanded or dropped.

Prior to this study of strategies Christian nurses use to create healing environments, Benner’s (1994; Benner & Wrubel, 1989) scholarly, philosophical descriptive caring and interpretive phenomenology were influential in this researcher’s thinking. Additionally the phenomenological philosopher, Merleau-Ponty (1962, 1963)

provided a helpful understanding of body-spirit unity. He developed the concept of the phenomenal body as subject (versus object), always ready-to-action with *teleos* built in. This understanding challenged the researcher to read and explore the amazing, innate power of the body to heal. Three primary authors incorporating philosophy of body-spirit unity also influenced the researcher and direction of this research. First, the spiritual formation writings of Willard (2002) centered on the centrality of will (will, spirit, and heart, as he defines them, are basically interchangeable) in God's creation of the person. Wholeness or well-being is seen in ordered relationships between the five components of the self (spirit, mind, body, social, and soul) and interaction with God and the environment (the world surrounding the individual person). Second, Goddard (1995; 2000) defined spirituality as integrative energy and as a philosophic, requisite precursor for holistic nursing. Third, Erikson (2007) developed the philosophy and theory for holistic nursing that affirms human nature as physical form infused with a cosmic energy. Holistic nursing draws from the cumulative knowledge of energy flow, also known as the universal consciousness, or Cosmic Consciousness, and holds this repository of knowledge as distinct from that of the American Nurses Association's (ANA) definition of holistic nursing.

The writings of Meleis (2010) and her doctoral nursing science seminar on the meta-construct of transition (LLUSN, 2012) focused on transition theory and encouraged this researcher to explore strategies nurses use to create a healing environment for patients in transition. Plans to do phenomenological research regarding the lived experience of nurses as they create a healing environment (versus a grounded theory study) were changed to use of grounded theory methodology after the researcher

participated in a Phenomenology and Narrative Discourse Analysis course by Sandelowski at UNC, Chapel Hill, summer 2012.

A Christian View of Healing and Well-being

Willard, a philosopher, ordained Christian pastor, and theologian (2002), asserts the infusion of “dust of the earth” with the “breath of life” results in formation of the human, a body-spirit unity. The human is given invitation and is intended to live in relationship with God the Creator and reflect this social-relational nature in relationship with others. God is the source of life. Therefore, prerequisite to wholeness or well-being is choosing to live in relationship with God and others.

Willard (2002) diagrams and explains the self as having five components: spirit, mind, body, social, and soul. Wholeness, or well-being, is depicted as the ordered functioning of these components in which God’s life can flow “throughout the whole person, including the body and its social context” (p. 41). *Will* (spirit, heart), as the executive center of the person, has the power to choose relationship with God or to choose life apart from God. Relationship with God is equivalent to wholeness where body-spirit unity is intact and expressed in the personal, social and corporate aspects of *shalom*. Commonly understood to mean “peace,” *shalom* expresses “the idea of totality, completeness, soundness, welfare, well-being, prosperity, wholeness and harmony. . . [It is] probably the closest word in the Old Testament to *health*” (Hui, 1997b, p. 483).

Life apart from God is where the heart has chosen to make *self* the God. That is, the body still has spirit capacity, but it’s a mere shade or shadow, dead and needing re-“breath of life” in order to be, once again, in relationship with God. A positive relationship with God structures and empowers the person, their relationship with others,

and becomes the foundation of wholeness, well-being, and health in the biblical Christian perspective. God's integrative work of creation means one can never be body apart from spirit. However, body with an inoperative spirit (where will or heart has chosen to ignore, or worse, separate itself from God) needs a re-vitalizing, fresh infusion of the "breath of life" in order to be whole.

In contrast to some who look to the Greek or Latin language as the basis for definition and understanding of person, spirit, and soul, Willard (2002) asserts that classical Greek and Judeo-Christian biblical sources that support heart, spirit, and will "are words that refer to one and the same thing, the same fundamental component of the person. But . . . under different aspects." (p. 29). This small executive center has the power to influence the other four components of the person for wholeness. A further look at this concept may be helpful. Willard continues,

"Will" refers to that component's power to initiate, to create, to bring about what did not exist before. "Spirit" refers to its fundamental nature as distinct and independent from physical reality. And "heart" refers to its position in the human being, as the center or core to which every other component of the self owes its proper functioning. But it is the same dimension of the human being that has all these features (p. 29).

Thus, the human is a multidimensional unity (Tillich, 1960) with will/spirit/heart at the center. In Willard's (2002) model of the person, the soul is the outermost place of organization of the whole person and is the interface with an infinite environment beyond the person. He pictures the soul having semi-permeable boundaries which limit the forces with which the person can interact. When this organizing and protective barrier is broken, the whole person is at the mercy of forces it cannot handle. Thus, illness potentially has sources that are spiritual, mental, bodily, and social in nature. As such, health reflects this wholeness, this inseparable unity, and in illness wholeness is

compromised, the person often experiencing brokenness in one or more dimensions of person. Because each person is a unity of all these dimensions, whenever one dimension is ill or affected, all are affected.

From a Christian, wholistic perspective, health includes being responsible partners in maintaining the gift of health. Hui (1997b) cautions this does not mean idolizing health, elevating it as the ultimate goal, or ignoring our “social responsibility in health as an expression of loving our neighbor” (Hui, 1997b, p. 484). The social, relational nature of health and wholeness is also the basis for the Christian view of healing. This means health and healing includes a reconciled relationship with God and others.

If health is multi-dimensional, well-being and wholeness, then healing becomes restoration of that social and relational wholeness (Hui, 1997a). One large faith-based health care institution, Loma Linda University Medical Center in Loma Linda, California, uses the words “to make man whole” as its motto. The goal is to restore wholeness including its spiritual, social, and relational nature. This view of healing, rooted in the Judeo-Christian scriptures, acknowledges healing is most often a journey of recovery of well-being. As stated in the delineation of concepts at the beginning of this paper, healing from the Christian wholistic perspective is recovery and restoration of wholeness in the individual and his or her relation to God, their community, and the environment.

Gaps in the Literature

Nurse as healer is one nurse role involved in creating a healing environment. As such, it is enfolded and somewhat disguised in the literature by close parallel and frequent intersection of the caring and healing aspects of nursing. As Swanson and

Wonjar (2004) indicated, caring and healing are inseparably integrated in a number of nursing theories and research studies (See also Woolley et al. (2012)). It could be helpful to investigate if Christian nurses differentiate these concepts and related ones (e.g., well-being and healing, or caring and healing environment) in practice. If, as Jarrin (2012) suggests, “nursing is caring situated in space, place, and time, shaped by the internal and external environments of both the nurse and the patient/client” (p. 17), creation of a healing environment can be a metaphor for promoting well-being. Subsequently, a healing environment can be fostered by actual situation-specific actions and attitudes.

While it is becoming widely accepted that spirituality plays a key role in health, healing, and well-being (Faull et al., 2004; Holt, Lee, & Wright, 2008; McCraty, 2003; Saroglou, Buxant, & Tilquin, 2008), studies which articulate nurse strategies for promoting health, healing and well-being, and the role nurses play in this area are needed (Meleis, 1975, 2010). Hence, one gap this study seeks to address is how Christian nurses promote healing and enhance well-being. Gathering data from Christian nurses employed in faith-based institutions allows for system-wide and organizational culture aspects of a healing environment to be identified as well as the direct care-giver role in creating a healing environment.

Additionally, studies that emanate from a Christian perspective may identify commonalities and highlight differences in nursing practice and outcomes between a unitary being or energy-based philosophy/perspective and a Christian perspective. This study also seeks to identify the strategies Christian nurses use to create a healing environment that may offer comparison of these outcomes with previous holistic theory-based studies. If it is true that focus, compassion, and intention are the three prominent

antecedent healer attributes (Levin, 2011), studies should further investigate these healer characteristics qualitatively and quantitatively. For instance, qualitative questions to describe how nurses focus their efforts toward healing and creating healing environments, how nurses develop their own and the patient's interest in, or desire for, healing (intent), and how nurses demonstrate or communicate compassion could uncover nursing therapeutics consistent with specific nurse and patient aggregates. This study addresses the first of these healer attributes, focus.

CHAPTER THREE

METHODOLOGY

This chapter details the research approach, design and ethical issues that were implemented to explore the strategies nurses use to create a healing environment and enhance well-being in hospitalized, non-end-of-life patients. Grounded theory (GT) is a method of inquiry which generates theory from data and results in an integrated set of conceptual hypotheses about the interaction of nurse, patient, and the creation of a healing environment. Face-to-face interviews explore several research questions with data sources and data gathering procedures explained.

Research Purpose and Research Questions

The purpose of this study is to explore the strategies Christian nurses use to create a healing environment and enhance the hospitalized patient's well-being. Specific aims include identifying Christian nurses' perspectives on (1) the strategies nurses use to create a healing environment and enhance well-being, (2) the outcomes they perceive resulting from these strategies, and (3) the factors they regard as either enhancing or inhibiting the creation of the healing environments. Five research questions are

1. What strategies do Christian nurses use to create a healing environment and enhance a patient's well-being?
2. What outcomes have resulted from these strategies?
3. What factors promote a healing environment?
4. What factors act as barriers to a healing environment?
5. What are characteristics of Christian nurses who create healing environments and enhance well-being?

Research Approach and Design

In this study classic grounded theory (Glaser, 1978) was used for discovering how nurses create a healing environment and enhance patient's well-being as he or she moves toward healing and recovery. GT is rooted philosophically in symbolic interactionism (Blumer, 1969) and methodologically in Lazerfeld's quantitative methodology and qualitative math (Glaser, 1998). Glaser and Strauss's first methods book, The Discovery of Grounded Theory (1967) described the process used in their "Awareness of Dying" work. This description provided the lens to see grounded theory methodology at work. The expectation of grounded theory is generation of substantive theory and, potentially, a broader, integrated, more conceptual level of theory (Artinian, Giske, & Cone, 2009; Glaser, 1978, 1998). There are currently several different perspectives on how to use the GT method, including the original approach of Glaser and Strauss. Glaserian grounded theory (GGT) is the chosen method to study how Christian nurses create healing environments and enhance well-being in patients because it focuses on the challenge or problem as the nurse sees and understands it (Glaser, 1978, 1998).

The Researcher

The researcher is the instrument through which the study is implemented. Thirty-five plus years of nursing (including acute, community, and faculty settings) contribute to competence and expertise in the nurse-as-healer role. The researcher acknowledges her own biases that developing the nurse-patient relationship and engaging the patient as partner in healing are critical steps in the healing process. However, grounded theory methodology requires that the researcher enter the study as one who does not know the participants' main concern. Relinquishment of one's preconceived ideas, hunches, or

personal agenda is the beginning point for grounded theory (Artinian et al., 2009; Glaser, 1998).

To overcome researcher biases, the qualitative semi-structured interview guide contains open-ended questions about the nurse's perceptions and practice of creating a healing environment and enhancing well-being in the patient. Data collection and analysis were reviewed with a methodology consultant to minimize researcher bias or contamination of any part of data gathering, analysis, or reporting.

Participants

Participants in the study are volunteer, licensed RN's who work at participating hospitals. Thus, a criterion-based purposive sample design was used (Patton, 2002). Two large, faith-based hospitals in southern California were used to recruit nurses who met the following criteria: (1) was a registered nurse with at least two years of work experience, (2) worked as a nurse an average of 10 hours per week or more, (3) worked primarily with adult clients on non-end-of-life units – this included critical care units, (4) comprehended, read, and spoke English, and (5) declared a Christian worldview. After letters of support from the participating hospitals were received, the Nursing Research Council at LLUMC and the nursing department at Methodist Hospital, Arcadia, assisted in nurse recruitment at their hospitals. The nurse managers identified a list of nurses who were exemplary in creating a healing environment. Subsequently, the snowball technique was employed with the repeat of an electronic invitation to participate, followed by the same procedures listed above. The number of nurses needed for the qualitative interviews was determined by reaching data saturation (a maximum of thirty was proposed) with the possibility of interviewing each nurse twice. Data sources include

individual interviews, field notes from these interviews, and an “Information about you” sheet.

Ethical Procedures and Protection of Human Subjects

Protection of human subjects involved going through the Loma Linda University (LLU) Internal Review Board (IRB) and, once approved, through the IRB of hospitals willing to participate, as stipulated. The Faculty Research Council (FRC) grant funding committee at Azusa Pacific University accepted LLU’s IRB approval as did Methodist Hospital of Arcadia. Thus, no other IRB approval was needed. When approved, the researcher worked in conjunction with the hospital/nursing administration to identify nurse managers who gave a global list of five or six nurses known on their unit with expertise in creating a healing environment to enhance well-being in the patients. The Fast Fact Sheet (Appendix E) and an email script (Appendix G) were sent electronically to inform these nurses of the study and invite their participation. If the nurse was interested in participating, he or she responded electronically or by phone to the nurse researcher. If the nurses had not responded within a week, the Office of Nursing Research at LLUMC or the department of nursing at Methodist Hospital gave a follow-up call to the nurse. The Health Insurance Portability and Accountability Act (HIPAA) requirements were met at all levels of data collection and analysis, and alpha characters were assigned participants for reporting purposes.

Grounded Theory Methodology

Data Collection and Procedures

Because the hospital environment is significantly different from the patient’s natural environment, the nurse is the person-at-hand who helps the patient navigate this

challenge. Therefore, exploring, understanding, and explaining the nurse's perspective, meaning, and action are crucial to understanding how the nurse creates a healing environment and enhances well-being in hospitalized patients. Semi-structured interviews were conducted using open-ended questions and probing questions based on the study's five research questions (Appendix C). Nurse interviews continued until no new information was obtained and data saturation occurred. Thus, it was not possible to determine ahead of time, only approximate, the number of participants in the study (maximum $N = 30$). The total number of nurses interviewed was 18, but two were excluded because they did not declare a Christian worldview, and one practice interview did not meet all study parameters. The first two were practice interviews, and the data from one of these was added after the core category had been identified in the analysis phase. No new codes in the data were identified after interview number 12. Thus, two additional interviews were done after data saturation occurred, plus one practice interview was added at the end for its rich data.

The GGT study began after contact was made through the participating institution's nursing department. Once nurses responded as interested in participating, a phone or email appointment for the first interview was made. If the nurse wanted to see the consent and the interview questions, the researcher sent an electronic copy ahead of time. Informed consent (Appendix F) took place at the first interview; a copy was given to the nurse and the original was kept in a locked drawer in a locked office. Once the first interview was completed, the snowball method of recruitment utilized the nurse interviewed to recruit peers he or she perceived as skilled at creating a healing

environment. Once the names and email of nurses were received, the above procedures were instituted for contacting and inviting the potential nurse to participate in the study.

There were slightly different approaches in the different hospitals due to administrative requests. These differences included the nurse managers and interim director of nurse education and research giving additional recommended names of nurses. After the first email, attempts did not result in any nurse respondents.

The socio-demographic data (Appendix D, the Information About You sheet), collected at the first interview was used for description of sample participants. Once the first interview was completed, data analysis began as described in the data management section. The second interview was conducted within six months of the first to discover further data about strategies nurses used and for theoretical sampling about substantive categories identified in the analysis to date. Every participant received a small thank you gift (a local gift card of \$15) after completion of the interviews, and several sent email or phone text words of thanks for recognition of their participation.

Data Management Plan

Data were collected during interviews (45-90 minutes each) and field notes written after each interview. A follow-up second interview was planned for theoretical sampling of ongoing data analysis, and five of seven nurses contacted completed a second interview. The interviews were audio tape recorded, transcribed verbatim, and checked for accuracy before entry into NVivo (version eight), a software data management program, and analysis began. NVivo serves as a storage and retrieval system for the labeling and organization of the codes, memos, properties and relationships between codes in the constant comparative process. The researcher used

GGT to read, code, memo, and identify concepts, properties, categories, and relationships between categories present in the interview data while continuing data collection.

Subsequently, emergent substantive categories were identified, and selective coding and theoretical sampling for the core variable was done. From this data immersion perspective, the researcher then generated a proposed conceptual model of what was really going on and how the challenge was continually resolved: In this case, “accounting for the processing of the problem” (Glaser, 1998, p. 11), that is, how nurses create a healing environment to enhance well-being of hospitalized patients.

Data Analysis

Open Coding

Analysis in grounded theory begins with no preconceived codes or concepts brought to reading and coding the data, termed open coding. On the first read the researcher codes every concept that stands out as important. When comparing one incident with another for similarities and differences, the initial discovery of concepts, properties, and categories results in themed grouping and patterns becoming visible. As patterns are categorized, different or dissimilar incidents often indicate a property of a category (Glaser, 1992). In this initial step, the researcher is “constantly asking of the data the neutral question ‘What category or property of a category does this incident indicate?’” (Glaser, 1992, p. 39).

The grounded theory researcher employs the five S’s of grounded theory: subsequent, sequential, simultaneous, serendipitous and scheduled, in no set order (Glaser, 1998, p. 15). The five S’s describe an approach to the data collection and analysis process: the researcher collecting, coding, and analyzing data while memoing,

categorizing, sorting and writing. This ongoing process allows constant comparison to (1) validate or alter categories and relationships as earlier identified, and (2) “discover the underlying patterns . . . with the meanings related to the behavior of the participants” (Glaser, 1992, p. 49). For example, after the first three interviews, the researcher consolidated codes into general categories of strategies nurses used to create a healing environment. While interviewing the fourth nurse, a nurse-patient interaction described exactly what one of these categories described, but with a new twist: “that purpose for life . . . it’s inherent in everybody.” Now, the researcher was alert to listen for what she (and subsequent nurse interviewees if they mentioned this) understood purpose to mean, and how she utilized this information to create a healing environment for this patient and for others in her care. Thus, discovery of patterns with the meanings for the nurse were solicited. Strategies identified in this first set of interviews included communication, educational, spiritual, formal institutional and informal peer support strategies.

Substantive Coding

As one consolidates open coding into themed groupings, categories of major importance are identified; this is also called substantive coding. Immersion in the data (listening and re-listening to previous interviews as part of analysis while continuing to interview more nurses) allows codes to be merged, dropped, or renamed; themes and categories to be consolidated, to be grouped anew; and properties and relationships within and between codes and categories to begin to be clarified. Analysis continues, and, amidst data gathering, reading, and coding, the researcher is always asking: “What is the main concern of the participants?” (Glaser, 1998). In this study, the specific focus was: “What is the main concern Christian nurses are attempting to resolve as they create

a healing environment and enhance patient's well-being?" The researcher's understanding of this main concern may change several times in the data collection and analysis phase. The inductive grounded theory method gives explanation of a phenomenon as understood by the participants, that is, how nurses understand the main concern in the process of creating a healing environment and enhancing well-being, and in a way that reveals how the concepts, meanings, relationships and patterns are related. Thus, the explanation is not a description of the data. Rather, it "emerges to explain the preponderance of behavior in that area, which behavior is the continual resolving of the participants' main concern" (Glaser, 2001, p. 5).

Thus, the first conceptualization of substantive categories included three groupings within the "helping them get better model" for formulating initial hypotheses of how the concepts related to one another. All of these seven groupings (substantive codes) were retained in the final model while only one of the three umbrella conceptual groupings remained the same.

Theoretical Sampling

Theoretical sampling starts from the beginning of data collection, open coding, and analyzing. The use of constant comparative analysis between interviews, categories and their properties helps the generation of "where next" ideas for data collection (Glaser, 1992; Glaser, 1978). The first example of theoretical sampling for this researcher occurred in interview number three when she realized a pattern was repeating itself. The first two nurses interviewed embedded institutional programs or supports in the patient exemplars, and here was the third nurse doing the same thing. As a consequence, the researcher added a question to the interview guide as a reminder to explore the formal

and/or informal programs and supports and how they helped the nurse in creating a healing environment. Theoretical sampling continues throughout analysis to assist the researcher to select areas in which further data collection is needed. Theoretical sampling instructs “what next” with data collection or answers the “why” questions of memoing. Data collection becomes focused on questions about structural and patterned relationships between categories.

This focus on relationships between previously identified categories informs ongoing data collection and leads to theoretical data saturation where no new incidents or differences between incidents are observed in current data. In this patterning one category appears related to many other categories and becomes the core category around which the grounded theory is constructed (Glaser, 1998). With patience, emergence of latent substantive theory becomes visible as what or how the main concern is resolved. Present in this theory are the substantive codes “which build the conceptual theory but are not the theoretical codes” (Glaser, 1978, p. 11).

Open Coding Ceases

In this study nurses understood the main problem as “helping them get better,” and this point was evident by interview number three. Often this identification of the main problem and the search for how nurses solve it goes through several evolutions before a core category is identified. Once the core category is identified open coding ceases, and the researcher narrows coding to selective coding.

Selective Coding

Selective coding limits coding to variables related to the core category; thus, groupings of consolidated codes clarify the substantive coding categories, and concepts

and patterns begin to emerge from the data (Giske & Artinian, 2009). An example of selective coding in this study comes from the initial second interview. One nurse identified a category of seeing from the nurse's point of view (in addition to seeing from the patient's point of view), and selective coding identified this category in other interviews. This is also another example of theoretical sampling and a more detailed description of this type of sampling is included in chapter four under "Seeing from the Nurse's Point of View."

Theoretical Coding

Theoretical coding is not essential to a substantive theory within GGT. But theoretical coding is essential to the next level of abstraction in showing how a number of categories consistently relate to the core category and one another within a grounded theory. Identification of a theoretical code increases the fit, workability, grab, and relevance of any theory. For example, the researcher may have identified a causal loop which because of a yet-to-be-discovered pattern will change to a reinforced strategy.

It is at this point that theoretical coding, implicit in the data, may be identified, extend integration, and offer models for theory generation. Glaser (1978) cautions the use of theoretical codes to avoid forcing data. Simultaneously, Glaser insists grounded theory is not complete, nor at its highest level of abstraction and applicability without a theoretical code. He expounds, "Theoretical codes give integrative scope, broad pictures, and a new perspective" (p. 72). Thus, Glaser's maxim to talk substantively and think theoretically regarding how codes are related to one another comes into play. The power of the theoretical code is that of an emergent guiding framework for theory development.

Understanding meanings involved in the everyday experience of these nurses as they create healing environments and enhance well-being will further enhance the fit, workability and relevance of the nurse's resolution of the main concern and emergent theory. As analysis proceeds, literature review data may be added for constant comparison. The findings will be explored in detail and in-depth analysis will move the emergent theory from substantive to formal. This is the point at which the researcher will decide if a sensitizing framework is reinforced by the data and adds to the application of a particular theory or not.

CHAPTER FOUR

FINDINGS

This chapter reports the study findings of strategies Christian nurses use to create a healing environment. First, demographics of the nurses interviewed and definitions of a healing environment and well-being are given, followed by a differentiation of these terms, as shared by the nurses interviewed. Next, an overview of general strategies nurses used to create a healing environment and enhance well-being in these hospitalized patients is followed by report of the barriers the nurses encountered in this process. Then, the specific strategies nurses used to chart the healing path for their patients are shared with supporting nurse data and quotations. This section on specific strategies includes a modicum of methodology to clarify how analysis yielded the conclusions drawn. Outcomes of creating a healing environment are included in this section. Lastly, nurse characteristics are described.

Participants

Sixteen nurses agreed to participate and were interviewed. Two nurse interviews were deleted from the sample because the researcher noted on the Information About You sheet that the nurses stated they had no religious affiliation, and, when this was clarified, both stated they did not consider themselves Christian. After the core category was identified in the data, one practice interview was added to the data pool. Thus, all qualitative analysis and statistical data are based on the 15 who self-identified as Christian. See Table 1 for a composite of this data. Their self-reported religious belief and affiliation included 3 Catholics, 1 Pentecostal, 3 Seventh-day Adventists, and 8 of

Table 1

Demographic Data

Participant		AA	BB	CC	DD	EE	FF	GG	II	JJ	KK	LL	NN	OO	PP	QQ
Gender	M											x	x	x		
	F	x	x	x	x	x	x	x	x	x	x				x	x
Age	yrs	49	61	51	27	27	52	28	28	25	27	37	30	37	30	42
Ethnic bkgd		C	C	C	F	H	C	C	H	C	H	C	F	H	C	C
Nurs educ bkgd	AD	x		x		x			x				x			x
	Dip.															
	BSN	x			x		x	x		x		x	x	x	x	x
	MS		x		student			student			x	student				x
Doct.																
# yrs/nrsg	yrs	25	4	20	5	4	10	4	2.5	4	5	3	6	1.9	6	14
Work setting	type of unit	M/C health	Acute med/surg	L&D, mngr	CCU/ICU	Surg / Tele/Onc	Med / Surg	Neuro ICU/trauma	Cardiac Tele	Med Surg Tele	ICU	ED: peds ICU; adult med surg	Cardio Tele/ICU	Post Op: plastic, Uro, Ortho	onc	L&D educ
Avg # of hrs/wk		24-36	36	40-50	36	36-48	38	36	36	36	36	42	40	36-40	36	20
Avg nrs-pt ratio		1:4 (8 mom/baby)	1:3-5	1:1-2	1:2-3	1:3-4	1:3-4	1:1-2	1:4-5	1:4-5	1:1-3	1:2-4	1:4-5	1:3-5	1:4-5	varies
Usual shift worked	Days	12	12	12	12	12	12	12	12	12	12	12	12			10

	Nights														12	12
	Other															
Relig. **		CH	CH	ND	SDA	SDA	CH	SDA	Cat	CH	CH	CH	Cat	P	CH	Cat
Where have you received info about creating a h. env. for pts?	Nsg Sch		x		x	x	x	x	x	x	x	x	x		x	x
	OJT	x			x	x	x	x		x		x	x	x	x	
	Grad Ed.										x	x				
	CE											x				
	Other							obsrv				church		church		church

Legend: * C=Caucasian, F=Filipino, H=Hispanic
 ** CH=Christian, ND=non-demoninational Christian, SDA=Seventh-day Adventist, Cat=Catholic, P=Pentecostal

other Christian denominations. The age range was 25-61 years with an average age of 36.7, and seven of the interviewees were under 30. Three nurses held associate degrees only, nine had bachelor's degrees (3 of these also had associate degrees), and five had master's degrees (with another three currently enrolled in a master's program). Three of these nurses did charge and bedside nursing.

Years in nursing ranged from two to 25, with an average of 7.6 years. Practice areas represented were acute medical/surgical, combination of surgical or cardiac units and telemetry, intensive care units including cardiac and neuro/trauma units, labor and delivery, oncology, and emergency department. Consequently, the nurse patient ratio ranged from 1:1 to 1:5, and 1:8 for labor and delivery with four mothers and four babies. All nurses interviewed worked 12 hour shifts, most working 36 – 40 hours per week. Thirteen nurses worked day shift; two worked night shift. None of the nurses interviewed were certified holistic nurses. The most common methods of receiving information on how to create a healing environment were “in nursing school” and “on the job training,” with 14 nurses marking one or both of these options. Two nurses identified graduate education courses, and only one nurse listed a continuing education course as a source of such information. Four nurses marked “other” with explanations given as observing or learning at church. In the narrative that follows, the nurse contributing the data is identified by an alpha character, e.g. AA, BB.

Definitions and Terms

The following definitions are compiled from the nurses interviewed in response to the first set of interview questions: (1) For you, what is well-being and what contributes to the patient's recovery of health and well-being while here in the hospital? (2) How do

you define a healing environment? (3) Are there distinctions you would make between a healing environment and that which enhances well-being in the patient? (see Appendix C). Thus, these definitions are the ones generated from the data analysis and serve as background to the “charting the healing path” model.

A Healing Environment

A healing environment is one that is patient-centered with needs being heard and addressed in a compassionate manner that engenders trust and comfort knowing another has the best in mind. This physical and relational space fosters rest and growth toward health and recovery where the patient gains or regains in partnership with the nurse confidence in knowledge of the recovery process and ability to face whatever health challenges lie ahead. In the midst of this process, the nurse is being a positive presence to “. . . help that person discover what might help them heal” (Nurse BB).

Focus on the patient is seen, as one day shift nurse (BB) verbalizes: “. . . it’s all about them. What are they thinking, worried about, what do they need in order to rest and get better?” A night nurse (OO) affirms this same, patient-centered focus by speaking of patients as people lying in bed wanting “someone to hear them, they want to feel important We need to make ourselves available to them . . . and just grant them time to speak . . . and be heard.” Multiple nurses spoke of introducing themselves (Nurse AA, CC, JJ, NN, OO, PP) to the patient in a manner in which the patient knows not only how to contact them, but that the nurse is there is for him or her. Or, as one young nurse (II) said, “You want to make them feel like they’re in control because they really are. It’s not what you say goes; it’s the opposite. They’re the patient; we’re focusing on them and they’re the boss.”

Well-being

Well-being was defined as a state of wholeness—an optimal balance of the physical, social, mental and spiritual aspects of self. One cardiac nurse (DD) emphasized, “We create well-being when we see the person as wholistic and see the connections between physical health, emotional health, and spiritual health.” Well-being is also individualized: The focus is on what this particular person needs in order to return home and achieve his or her best possible outcome.

Nurses struggled to differentiate these concepts but eventually described the healing environment as that which surrounds and empowers the patient and contributes to a more personalized sense of well-being. As one nurse (KK) described, physical healing may not be primarily what the patient needs for well-being. She concluded, “I think trying to figure that out [what contributes to well-being] is the harder process.” These nurses described both the healing environment and well-being as wholistic and individualized, but consensus was that the influence was uni-directional. That is, creation of a healing environment facilitates or enhances well-being; whereas, well-being is not essential to the creation of a healing environment.

Strategies and Barriers in Creating a Healing Environment

In using NVivo software for data management, the first level of coding is termed open coding. Open codes are merged and combined with similar codes for organization and conceptualization purposes. Of the initial 172 NVivo open codes, three consolidated codes were developed directly from the interview guide questions. These three were (1) barriers to a healing environment, (2) enhancers to a healing environment, and (3) outcomes. Another seven consolidated codes came from reading and analyzing the first

three interviews and are numbered for clarity: (4) availability, (5) communication strategies, (6) partnering, (7) spiritual strategies, (8) educational strategies, (9) structural or facility supports, and (10) seeing from the patient's point of view.

General Healing Environment Strategies

Nurses talked at length about strategies which the researcher has consolidated into five themed groupings. These generalized strategies developed in the first level of analysis, open coding, may overlap and be present in more than one grouping. They include communication strategies, spiritual strategies, educational strategies, institutional strategies and supports, and informal peer support strategies. These generalized strategies will be integrated into the "charting the healing path" model and the specific healing environment strategies which comprise this model. Thus, citation of individual nurse quotes will not be presented in this section. Rather, they will be presented in the section which presents the "charting the healing path" model.

Communication Strategies

Communication strategies named by nurses included offering dignity and respect, building trust, hearing immediate concerns, and listening which allowed patient needs to unfold and be addressed with readiness for relationship and/or action. These communication strategies were essential to the nurses' focus on spiritual and educational strategies.

Spiritual Strategies

Spiritual strategies reported by nurses were wholistic assessment, initial and ongoing spiritual assessments, and interventions. Interventions reported were raising spiritual awareness, offering to pray, praying with patients, praying silently for patients,

acting with compassion, honoring spiritual routines or practices in the care giving schedule, having conversations focused on patient concerns, and sharing spiritual stories when appropriate. One nurse made explicit in her assessment whether the patient had ever established a relationship with Jesus or not, and two nurses were ready to intervene by offering explanation and prayer for that salvation relationship if the patient was interested. See Table 5 for a sample clustering of codes related to spiritual strategies.

Educational Strategies

Educational strategies ranged from orientation to the hospital facility and hospital routines to patient and family teaching on disease, illness, and health care. These addressed readiness for discharge, patients being confident in self-care abilities before leaving the hospital, and use of a multitude of resources for health promotion. Labor and delivery nurses majored in these educational strategies from the moment of patient arrival (birth plans and readiness for the birth event) until patient departure (parents knowing how to care for themselves and the newborn at home).

Institutional Strategies

Institutional strategies included unit and or hospital-wide strategies and varying degrees of involvement from nurse managers and hospital administration. Quiet hour or “quietly healing” programs were found in both hospitals at unit or hospital-wide levels. Likewise, both hospitals offered non-medicinal therapies designed to promote healing intervention for the patients. These types incorporated several of the following options: massage therapy, pet therapy, healing garden therapy, key words at key time initiatives, and the more typical physical and occupational therapy, social work, and chaplain services.

Additionally, nursing units had programs such as

1. Very important person (VIP) designation for nursing staff, selected by nurse managers, who promoted spiritual care at patient, staff, and unit levels.
2. Initiation of bedside reporting, hourly rounding, and nursing zones facilitated inclusion of patients in the care team, increased patient involvement and satisfaction, and nurse availability for patient interaction.
3. “I care cards” encouraged patients and staff to recognize exemplary nursing care.
4. A wide variety of educational resources increased patient knowledge and participation in their care. Many nurses also indicated that exceptional charge nurses were valuable institutional supports.

Peer Support Strategies

Creative nursing-support approaches increased teamwork and collaboration. Nurses named supports as follows: resource nurses; nurse preceptors; charge nurses; meal relief nurses; the possibility for changing assignments, when needed; and nurses encouraging one another for emotional well-being breaks in the middle of a shift, as needed. Nurses had impressive stories of giving and receiving personal peer support.

Barriers to a Healing Environment and Well-being

Though the list of barriers addressed by these nurses was quite lengthy and detailed, the researcher has grouped them into three basic categories: patient-related barriers, including cultural challenges; nurse-related barriers, encompassing care-giving staff and staffing issues; and hospital structural and process-related barriers. Each of

these three is further parsed for rich description and understanding of the perceived challenges.

Patient-related Barriers

Lack of Adherence

Patient lack of adherence with recommended medical regime or nursing care was, by far, the most frequent barrier nurses reported. One nurse (II) gave two common reasons for a patient's possible non-cooperative attitude: (a) patient perceived limitation: "You know it's really important for them to walk and use the incentive spirometer, and she was just saying, 'I'm too tired, I'm too tired.'" and (b) previous negative experience: "Sometimes when they've already had a bad experience before you, then they're skeptical with everybody else and they're already upset because of the previous situation." Thus, the challenge to ensure patients' cooperation is often layered, requiring the nurse to be a sleuth with assessment and relational skills.

Patient's Emotional Needs

Patients' emotional needs can frequently trump the physical needs by their focus on some factor(s) external to the reason for hospital admission. One seasoned nurse (BB) described what she perceived as extreme when a 51-year-old, chronically ill patient was "weepy, needy and teary because her mama didn't come see her in the hospital that morning." A much younger nurse (EE) heard a post-op, nothing-by-mouth, patient's request to save any unused trays for her son as the opening to explore what the issues were from this patient's perspective. Both nurses recognized these emotional needs as major barriers to healing.

Behavioral Challenges

Lack of patient adherence is also often accompanied by behavior which severely challenges the nurse and the care system. One young, energetic nurse (DD) sadly told of the rude, cursing, uncooperative middle-aged patient who defecated on the floor and other places, refused anything the nurses offered, and said the nurse was incompetent. The nurse's only consolation (of sorts) was that she treated every nurse this way. Only one street-smart patient care attendant (PCA) who "pretty much gave her back the rudeness that she was giving to everyone else . . . won her trust." A male nurse (NN) described a 33-year-old Latino gang member as "a troubled young person . . . very resistive, very combative" who was self-destructive and ultimately had to be removed from the hospital. This compassionate nurse sorrowfully recounted not being able to make connection with this patient, who needed cardiac care.

Family Involvement as Potential Barrier

While family members can be a huge source of support, they can just as easily become a barrier to creating a healing environment. One nurse (KK) described an elderly patient whose lack of knowledge regarding post-operative care was compounded by his cultural norm of being totally dependent during surgical recovery, and the family upholding this. "I think the patient was very willing in the beginning when we made the goals, but when the family was there . . . they didn't want [him] to do anything." This same nurse described another situation in which an older, compromised surgical patient did not want to make decisions without his family. With the patient highly unstable and the family absent, the care team was hindered in decision making; a real barrier existed.

Two labor and delivery nurses (AA, CC) gave examples of families arriving at the unit with their birth plans “fixed” and perceiving the nurse as “the enemy” when giving any suggestion that did not fit their plan. One nurse (AA) described how both a mom and dad reprimanded the baby nurse for drying the baby too vigorously. She understood her challenge as needing to educate and redirect the resistance to engage both parents in giving appropriate care to their newborn. Still, the dad sabotaged the baby nurse’s effort to adequately dry and later warm the baby. This situation happened even though the baby nurse attempted to instruct and include the dad in the process.

The nurse recalls how their attitude shifted as soon as they were beyond the immediate time interval covered by the “fixed birth plan,” and they and the baby nurse arrived on the post-partum floor. Once beyond their birth plan, they were open, receptive, and so thankful for whatever instruction and care the nurse gave.

Excessive Noise and Drama

An ICU nurse (GG) observed that a family’s involvement sometimes has to be limited due to the excessive noise and drama in response to a patient’s condition. In circular units, such noise is heard throughout and may require the family being escorted off the unit. Additionally, this nurse shared an example of inappropriate communication by one care-giver about sedation vacation for a vent-dependent patient which resulted in multiple family members showing up for an event that could not happen. “. . . Some of them weren’t happy about it. . . [it was] something you can’t really control. So you just explain . . . several times in different ways, because you can just see they don’t quite grasp it.”

Language Limitations and Culture

Language limitations and cultural differences, as cited in examples above, can cause misunderstanding and present barriers to creating a healing environment. A labor and delivery nurse (AA) described patients and families from different cultures arriving for delivery who speak very little, or very broken, English. With Asians, in particular, she explained that the generational dissonance of care norms and expectations make it

difficult to advocate for the patient. . . . we've got the mother-in-law taking care of everything. I mean they are covering up the patient so they don't get cold, "you can't take a shower," bringing in the food. And, I don't speak Korean or Chinese . . . so I can't really talk to [the mother-in-law], can't advocate. I remember one Korean patient, when her mother-in-law finally left, the new mom said quietly, almost whispering, "Don't tell her, but I'm going to shower."

The problem is compounded as the older generation believes and practices their birth rituals, ". . . but the younger generation is Americanized and don't believe half of it, so, it's often a barrier to a good environment for recovery."

A bilingual nurse (II) recounted what prompted a fellow nurse to request changing patient assignments mid-shift. An older, Spanish speaking cardiac patient refused the next level of diagnostic tests and all care offered. She scratched the certified nurse assistant, hit the nurse, and wanted nothing done to her. The nurse agreed to go meet the patient and recounts the following:

. . . and I started talking to her in Spanish and talking about her family, and "oh, where are you from?" "Oh, I'm from un pueblito, a small town in Mexico." Then I said, "Oh, well my parents are from Aguas Calientes," and we started forming that relationship, and she was so calm, so much better afterwards."

These examples illustrate some of the barriers different cultures, languages, and beliefs about care create for the nurse.

Nurse or Nurse Staffing Barriers

The Nurse or Care-giving Staff

The nurses interviewed named nurse characteristics such as bias, arrogance, lack of job fit, lack of and/or inadequate communication, nurse fatigue, and nurse staffing issues as barriers. One nurse (FF) described helping a PCA from a different culture and a military background select an approach to an irrational patient to avoid becoming defensive .

“I was trying to teach her you can’t reason with him at this point because . . . he’s not looking at it rationally. You can’t rationalize with irrationality.” Her take home message was defensiveness is a major barrier to healing: “. . . the worst thing you can do is get defensive with the patient.”

Practicing Unaware of One’s Own Biases

Practicing unaware of one’s own biases is another barrier for creating a healing environment. One male nurse (NN) described his experience of discovering how he categorized drug seekers as evil. Only when he confronted his bias was he able to develop compassion and hear the patient’s story. He explained:

. . . just being able to hear that [the patient’s story] and see that, it really made me think and say, “you know, they’re not that different from us.” And I felt really bad for them. I felt like, ok, now I understand why you’re doing this. Now I understand this is your out.

Another male nurse (OO) described being in a room where his colleague acted arrogantly and insisted that the patient, who was in great pain and refusing to turn, must turn. “The nurse had the audacity to say, ‘Well, we’re nurses; we know better,’ and turned the patient. And that is that mindset of ‘we know better.’ What about the patient and their voice and their concerns?”

Nurse Fatigue, Frustration, or Lack of Trust

Nurse fatigue, frustration, or lack of trust can also impede the healing process. The young cardiac nurse (DD) stated, “If you come in with a sense of impatience or you’re tired . . . patients will quickly pick up on that, and I believe that does NOT [nurse emphasis] foster a healing environment.” Likewise, frustration and discouragement with the behaviorally challenging patients previously mentioned can hinder the flow of creative healing approaches by the nurses.

One nurse (JJ) described the cuts in benefits and funding for nurses, created by the current economic situation, as a major barrier for nurses’ ability to offer their best to help patients heal. This nurse named nurse turnover and inadequate staffing as issues which negatively affect the creation of a healing environment. She explained,

We’re thin, we’re stretched, and we have a great deal of staff turnover. . . . I was a nurse one year and put into a charge position, and I’ve trained a lot of people A lot of them have left.”

A male nurse (LL) who works ED and pediatrics described the biggest barrier as “a care provider who is not happy about being there,” who does not love his or her job and helping others. This is seconded by the male nurse (OO) who stated “We [nurses] can be very negative, task-oriented people, creatures of habit that fail to address some of the more important issues.”

Hospital Structural and Process Barriers

Noise Levels and Time Pressures

Fourteen of the 15 nurses explicitly named noise as a barrier; one went so far as to suggest a quiet environment might not be possible. One of the hospitals in this study has circular units with the nursing station in the center and semi-private rooms. Nurses who

had worked in hospitals with private rooms always commented on the improvement that would bring to noise reduction. One nurse (BB) described the challenge when everybody is talking “and they don’t speak in library voices,” of promoting a quiet and restful environment. Another nurse (LL) explicated the series of noises: “There are tons of beeps and dings and alarms. Every alarm for every little thing . . . pushing each button is a beep. How can that be a good environment [for rest]?” Equating excess noise with threat to well-being recurred throughout the interviews.

Time pressures were also identified by nearly all nurses interviewed. Many nurses (AA, BB, DD, EE, FF, JJ, NN) named the conflict of wanting be with patients but having many other demands made on their time. Both day and night nurses (FF, OO, PP) talked about the challenge of updating charts versus spending time with the patient even when charting is done electronically in the patient’s room. Nurses recognize time as both an opportunity to be with the patient and the lack of time as a barrier when diverted from the bedside. Nurse FF summarizes these sentiments by saying:

It’s not being able to spend more time with the patient. You know, . . . all this time charting and running around, sending patients here and there, making and receiving phone calls, and then the most important factor, at the bedside, is getting lost, and it’s really sad.

A cardiac nurse (JJ) sighed while discussing the reality of seemingly endless other tasks that take her away from the patient: “so much paper work, state mandated this and that, forms to be filled out, logs, and, of course, there are many interruptions.” Time constraints were compounded by the high tech aspects of health care, particularly in the ICU. One ICU nurse (GG) readily offered the perspective that their unit is not person or patient-centered. Rather, it’s driven by stabilizing the patient’s physiologic numbers. “We want to make them number-wise look pretty.” And, since most of the patients on

that unit are not fully conscious, those are the parameters to trust and with which to evaluate successful patient care. This nurse did indicate she made communication with the patient's family a priority whenever possible.

Uncontrollable Events

Other barriers are the uncontrollable aspects of hospital routines, procedures, and personnel. When nurses are left to pick up the pieces, to apologize for that which is out of their control, challenge and strain result. This is true even when nurses rise to the occasion and do the formidable job of consoling, listening, and looking for ways to "make it better." That phrase appeared early in and throughout data collection and analysis to describe how nurses understand their main concern: helping patients get better. The behaviors which nurses use to address helping them get better led to development of "charting the healing path" model.

Charting the Healing Path

Helping Them (Patients) Get Better

Helping the patient get better was the main concern of nurses. Glaser (1978) states the main concern is the problem nurses are attempting to resolve by their behavior. Some first described this problem as helping patients "get better physically" and were then swift to include the wholistic aspects of care. See Appendix K for a coding sample from Nurse CC's interview and Table 2 for examples of clustering codes for this substantive code of "Helping Them Get Better." Almost always, the purpose of the interventions addressing this problem was the patient's "return to home, and being able to do what they need to do" (AA, BB, CC). The context of helping patients get better within these two faith-based hospitals was hospital-wide support of wholistic care. In

this milieu, nurses identified two parts of how they routinely helped patients get better. They reported their practice of (a) doing a baseline assessment and (b) being available to address wholistic patient-centered needs as the starting point for all that was yet to happen.

Baseline Assessment

Much is revealed in the process of doing one's baseline assessment, whether it is the admission assessment or a shortened version by each nurse on the shift of duty. Open codes listed under baseline assessment included pain relief, emotional concerns, and ongoing care. Three nurses identified specific clarifying information gained in their baseline assessment: (a) the patient's concern for children at home (EE), (b) the patient was clueless (and reasonably upset) as to why he was still in the hospital (OO), and (c) discovering the patient's reasons for continually asking for more pain meds (KK). This baseline assessment identified the starting point from which the nurse would help patients get better. A labor and delivery nurse (Nurse AA) described the importance of a late-morning patient arrival and baseline assessment when, near the end of the shift, she picked up rales and shortness of breath (SOB) after the delivery. The Korean speaking mother-in-law was trying to communicate to the nurse that her daughter-in-law had been tired a lot lately, but the nurse could not understand Korean. So, while language competence or fluency might have allowed the nurse to intervene earlier, the baseline assessment served to identify a change in patient status after four plus hours that warranted intervention.

Being Available to Meet Patient Needs

Each of the above situations also illustrated the importance of the nurse being

available to meet patient needs whenever they surface. Open codes listed under this category included availability for meeting patient's needs, patient or family feeling safe, tie up loose ends, connecting, and presence. As one night nurse (OO) said:

I think many nurses fail in this regard because they just want to get their job done or they're overloaded [or] understaffed and so that means that they're just too busy to just be available. . . . it is taking some time [later he indicates it's often five minutes or less], connecting with them, and letting them know that I am not just here to give [them] some medication. I'm here to address some of the other things in your life. How am I to know that? I don't know, unless I begin to talk to them and make that connection and tell them, "I didn't know . . . and how did this happen?" And next thing you know, because they want to talk, to be heard, they'll begin to tell you . . . about their life.

Several nurses offered that patients need to know the nurse's interest in caring for them, "and if there's anything I can get [you] throughout the day, don't hesitate to ask me. I'm always available." (JJ).

Nurses insist patients know whether a nurse is interested and available, or too busy. One ICU nurse (KK) indicated open-ended questions are always a part of her baseline assessment, and, at the same time, this dialogue continues throughout the day. "It takes, you know, your little moments of connection throughout the day that helps them to open up to you. . . . Don't leave them with the impression 'I'm too busy for you.'" One night nurse (OO) adds, "My job is to make sure that I'm available, and if we understand that role, it makes it so much easier." Another night nurse (PP) prioritizes being present and available throughout the shift and rapid response to the patient's agenda versus charting and other nurse agendas. She states,

So, for me, as a shift continues, and depending on how well someone is doing or not doing, I always just try to be in there. I think that's the big thing for me is trying to be on top of it [indicating on top of call aids]."

Being available offers the patient an opportunity to reveal more in an unfolding

environment of care. If skill in assessment or availability of the nurse is limited or truncated in the first interaction, so is progression towards a healing environment.

Fostering the Healing Environment

After initial open and substantive coding identified the nurses' main concern of helping patients get better, constant comparison of codes resulted in clustering groups of open codes into similar categories with properties and characteristics identified (Glaser, 1998). See Table 3 for examples of clustering codes for substantive area of "Fostering the Healing Environment." This clustering of codes into substantive categories gives the building blocks of theory and generates conceptual and theoretical thinking in the researcher. Glaser (1998) describes fracturing the data to see what is going on in the nurses' attempt to resolve their main problem of helping patients get better before putting it back together. Two aspects of being available, seen in the data, were being available to meet patient needs and being available for relationship. The latter seemed to focus more on fostering a healing environment by getting to know the patient as a unique individual and connecting with what was meaningful to that patient.

Knowing as a Unique Individual

Open codes generated in this substantive category included time to connect, discover commonalities, mutual introduction, reading the patient, meaningful for patient, and empathy. Two nurse comments summarized the importance they place on knowing the patient as an individual. One (JJ) highlighted the routine of a good, solid introduction where the patient knows how to reach you, who you are, and finding out a little about them;

what's going on" or "how they're doing." She stated, ". . . [it's] thinking of them as more of a person and not a patient. . . . not just as a medical patient. We're there to care for them and love them."

A male nurse on this same unit (NN) emphasized sick people need people, not machines, to heal, and he suggested a lot of nurses and other care-givers have "forgotten the fact that we're here to take care of patients." He listed many things that are not the nurse's primary focus--medications, treatments, doctors' orders, wounds--and continued, "People need people to heal. . . . machines actually help. . . . But in the end, ultimately it is us that they actually need, to heal and go through that process." Another, more senior, nurse (FF) identified empathy, insight, patience and being a good listener as prerequisites to the patient being known and feeling accepted. She cautioned, "There are a lot of stereotypes that go on in nursing and to be able to just look at them as an individual is important, I think, as far as grasping their needs." These nurses illustrated their belief in the importance of the patients being known for who they are, unique individuals, with unique needs that will surface as the nurse-patient dialogue proceeds.

Hearing Patients' Immediate Concerns

The open code of hearing patients' immediate concerns became its own substantive category in data analysis. That is, there were no other open codes which further described this category. The fact that multiple nurses described their behavior by this action validated it as a substantive code. Nurses know they gather a plethora of helpful facts and information about the patient, but asking open ended assessment questions allows the nurse to quickly hear the patient's immediate concerns. Glaser (1998) describes the subjects, in this case the nurses, as soon as they know they are being listened to in the research process, will "vent their concerns to the max" (p. 123). Nurses

concur the same is true for the patient to whom the nurse is listening. Building on the above senior nurse's comment (FF), she acknowledged the limitation of time without communicating a hurriedness or busyness that prevents discovering the patient's most pressing needs. She stated:

Well, I usually ask them, "What's going on?" You know, I start out with, I want to know where they're at, where they're coming from, are they afraid, are they in pain, do they have a lot of unanswered questions? What are they feeling, whether it's physical or emotional because I want to try to find out . . . and just deal with that issue right off the bat so that we can get to the bottom of things . . . to a lot of issues that often get missed.

This interaction demonstrates another strategy several nurses identified as crucial to forming a partnership with the patient: seeing from the patient point of view.

Seeing from the Patient Point of View

As in the previous substantive category, this open code became its own substantive category in data analysis. However, Table 3 illustrates how open codes of nurse attitudes, building trust, reading the patient's needs, empathy and communication, nature, healing, light, and family needs were consolidated to form this larger conceptual substantive category.

Understanding how a patient sees the situation allows the nurse to honor the patient's grasp of the current situation and incorporate that into the next step of an individually designed plan of care. These two elements of the "charting the healing path" model, hearing immediate concerns and seeing from the patient's point of view, are fluid and interchangeable, sometimes occurring simultaneously. Often the patient's perspective is discerned when the nurse asks more questions about his or her immediate concerns.

In the following nurse comments, this marriage of immediate concerns with patient point of view is illustrated. A cardiac nurse (DD) asked a diabetic patient, whose blood sugars were around 300, “How are you today?” and followed with, “Are your numbers always this high?” The patient indicated he had to stay this high for him to urinate. The nurse immediately thought education mode but decided to hear his side and let him talk. “. . . I was like, ‘Really?’ He says, ‘Yes, it’s a big problem and I know my body and you guys come in here and mess up my insulin regimen.’” In listening (versus teaching), she learned neither she nor the patient completely understood polyuria, advocated for the patient with doctors, and got his insulin regime rearranged to more nearly match his preferred home routine. While the patient was still assertive about his insulin regimen, he was now willing to work with this nurse in care planning. The nurse concluded:

And, so sometimes you hear things patients say and you just completely throw it out the window thinking, you know what, like I’m the nurse here and I should know. Yes, but you work with them, you work with them so that you’re able to, at the end of the day, to teach them more because you have built their trust. And so that was just one example of working [with], making the patient a partner in care and planning care which is a struggle in the hospital environment.

One ICU nurse (KK) insisted the healing environment begins with what is going on physically with the patient and must be matched with what is happening from the patient’s perspective. She asked the patient, “What are issues we may need to address today? What are your goals for today? You have to address their needs before you get into what you want . . . otherwise it seems like you’re kind of demanding.”

As second interviews commenced, substantive categories of (a) knowing as a unique individual, (b) hearing immediate concerns, and (c) seeing from the patient’s point of view had been identified, and these led to (d) partnering with the patient toward well-

being. These substantive categories in the deepening nurse-patient relationship described the behaviors of nurses who fostered the healing environment.

Another example of theoretical sampling occurred at this point. The first nurse, interviewed a second time, identified “seeing from the nurse’s point of view” as a missing element in the emerging conceptual model. After the researcher validated examples of this element in a rereading of the first interviews, it was added as a substantive code. Examples of this code found in first interviews, after second interviews began, include FF (day shift nurse) and PP (night shift nurse) who both explained that charting at the bedside was important to (1) hearing the patient’s concerns even if there was no verbal dialogue, and (2) informing their sense of what this person needs. “Seeing from the nurse’s point of view” is influenced by being in the presence of the patient. BB gives a description of how her point of view informed her action and partnership with the patient.

. . . I also took pictures of the wound because part of her healing is that she has to be able to look at that wound. She was able to see it when she had the tissue expander ‘cause it looked more normal, but once that tissue expander came out there was no mistaking that (pause) there was a breast that was gone. And it took her a couple of days to look at that, but by my last day, she was able to look at it and comes to terms with it.

Each nurse in the second interview confirmed that seeing from the nurse’s point of view was pivotal to charting the healing path. Thus, theoretical sampling happens in ongoing analysis to inform “what’s next” in data collection and analysis.

Seeing from the Nurse’s Point of View

Once selective coding has begun, one is no longer generating open codes that will be consolidated into this new conceptual category. Therefore, in Table 3, previously open codes of nurse anticipating needs, offering self and resources, nature, healing

garden and light did, at times but not always, explain the nurse's point of view. They are included with the conversation excerpt to show how they showed properties of the more conceptual category in that instance.

By virtue of education, experience, and caring presence the nurse interprets the patient viewpoint and brings to it the nurse's own perspective, own reservoir of knowledge and resources. This blending of patient and nurse points of view is an active processing of "What do I have to offer that this patient needs?" This is a conceptual shift in how the nurse works to solve his or her main problem of helping them get better. This implies a partnership where the nurse brings self and all one's attendant resources to create a healing environment with the patient.

Each of these nurses was astutely aware of their own perspective and willing to hold that in tension with the patient's point of view. Without awareness of one's own stance or view, the movement toward discovery of a healing path may be shut down. One male nurse (NN) detailed his personal attitude transformation toward drug users by listening to a heroin user admitted with cardiomyopathy. His judgmental attitude of "she's just [drug] seeking . . . she doesn't want to be healed" was changed when he heard her story of years of horrendous abuse. From that day forward, he knew the importance of hearing the patient's story and addressing the patient's perceived immediate needs infused with that unique background information. The nurse's ability to listen and remain open allows the patient to open and the story to unfold.

Another nurse (DD) showed her aptitude and skill with a belligerent, uncooperative, middle-aged woman who demeaned the nurse, called her "incompetent," refused anything she offered, and would only cooperate if a street-smart patient care

assistant (PCA) accompanied the nurse. She described how difficult this defeat was, how demoralized she was, as the nurse. Yet, she heard from the patient's behavior "this is the only way I'll work with you." The nurse heard this message through the patient's refusal to communicate anything with anybody, except the PCA. This belligerence necessitated that the PCA accompany her every time she went in the room. This nurse was able to change her "modus operandi" to find the most acceptable path toward health (however partial it was) from the patient's perspective.

If the nurse is unable to see from the patient's point of view, or the patient does not want to be known and share his or her perspective or concerns, the nurse fails to connect with the patient and the healing path is blocked. From the nurse's point of view, this block is often experienced as nurse failure even though at times the patient is unavailable for relationship or unwilling to receive the help being offered.

In this study, the nurse's point of view is a bridge to partnering with the patient toward well-being. Included in this partnership are all the components of being a nurse and a person of integrity. The emerging partnership was influenced by the nurse's level of skill and expertise, cultural understandings, personal strengths and biases, personal belief and faith commitments, and knowledge of other healing resources.

Charting the Healing Path

Partnering with the Patient toward Well-being

The "nurse's-point-of-view" bridge is described by the offering of self and the full array of resources available to strategize and chart the healing path via partnership with the patient and/or family. Table 4 gives conversation excerpts, codes and how they were clustered to give fit, workability, and relevance to the substantive codes of charting the

healing path: the substantive codes are partnering with the patient toward well-being, setting realistic goals, and facilitating best potentials. This is another point where theoretical sampling revealed a pattern of response that was then validated in previous and subsequent interviews.

This example of theoretical sampling occurred when the researcher and nurse consultant had just agreed that “discovery of the healing path” was close to being the core category but not quite complete. The next three nurses interviewed (KK, LL, and NN) each talked about elements of the nurse-patient partnership in a manner, which like fireworks, clarified multiple things. Partnership, they explained, involved setting realistic goals and facilitating next levels of health or best potentials. This explanation of behavior used to establish effective partnership was first coded as realistic goals, next level of health, and best potential. Seeing the pattern and properties of *partnering* emerge, use of constant comparative analysis and consolidation with previous codes of “unknown as potential barrier” [to partnership and moving forward] and “confidence in self-care abilities” helped identify the core category of *charting the healing path*. This code involved discovery, but the more dynamic, action-oriented properties of setting realistic goals and facilitating best potentials fit with the more active *charting the healing path* core category as compared to the earlier “discovering the healing path.”

The nurses in this study demonstrated that the nurse’s-point-of-view informed partnering with the patient. Advocacy, vulnerability, a readiness factor, mutuality, intentionality, and a spiritual reservoir were open codes identified during early or mid-phase analysis and emerged in a more substantial way during the memo sort. Instead of sorting open codes, the memo sort is a similar hand sort of all memos generated,

grouping according to themes and properties which show relationship of substantive codes to one another and to the core category. Although each of the above codes were identified by the researcher as influential in developing the nurse-patient partnership, none are substantive codes. The spiritual reservoir concept of the individual can be aligned with the institutional whole person care focus as one of the contextual factors which support the “charting the healing path” model. And advocacy, vulnerability and a readiness factor contribute to an effective partnership between nurse, patient and/or family.

Advocacy

Advocacy involved seeing a need and rallying resources to meet that need. Often, rallying resources included speaking on behalf of the patient, frequently to promote multidisciplinary involvement in creating the healing environment. It nearly always included getting all players on the same page, negotiating realistic goals in common, and expanding the options to achieve the patient’s best potential.

Nurse Vulnerability

Nurse vulnerability was expressed in multiple ways, but the essence was the willingness to share nurses’ humanity and intervene with their personal knowledge base supporting their actions. Sometimes this vulnerability included appropriately sharing a portion of a personal tragedy that was related to the patient’s present suffering or tragedy. At times it meant being surprisingly real, admitting error, saying, “I’m sorry,” and pursuing conflict resolution or reconciliation. In addition, it sometimes meant initiating action (intervention) with confidence, without time to include the patient on the front end of the partnership.

Nurse Readiness

Nurse readiness was seen as offering of self and other resources which were timely, pertinent, and meaningful to the patient. This readiness was depicted by communication that seemed to have that “just in time” quality that educators recognize as the readiness factor used in a teachable moment. It was also demonstrated by nurses cultivating a readiness to be used by God. The nurse who practiced physical, spiritual, and emotional health had these resources readily available and could creatively offer them to patients when needed. This readiness also helped the nurse see the connections between the physical, spiritual, and emotional realities that were present or lacking for the patient. Seeing these connections gave the nurse an advantage in charting the healing path, to initiate the partnership with a sense of “this is what will get us to the best potential.”

A Mutual Process

“Charting the healing path” is a process that moves back and forth between the nurse and the nurse-patient partnership. The initiative was almost always with the nurse, and the nurse was intentional in sharing the ongoing formation of the healing path with the patient. Facilitating the patient’s best potential was dependent upon the ability, desire, and commitment on the part of the patient and/or family to partner in reaching these goals.

Intentionality

To create a healing environment the nurse must be intentional, and have a desire to partner with the patient, family, and care-giving team. Nurses often took the lead in creating a plan of action with realistic goals for facilitating the patient’s best potential.

Most often, the patient would not know how to do this, but, in trusting the nurse, the patient can still be a full partner. When the patient understands the reasons for the plan, the patient's partnership is based on both trust and new knowledge. The nurse included the patient and/or family in formulating the plan whenever possible. This concept brought together all the pertinent information and valuing of the person, gathered to date, to chart a path directed toward healing and well-being. The healing environment upholds what the patient values and what the nurse and patient discover together is needed in order to move forward. It is here that the healing path was forged as goals were identified that took into account the patient's best potential and how he or she could achieve it.

Spiritual Reservoir

It is noteworthy that all but one nurse included spirituality as part of creating the healing environment. These nurses identified spirituality in giving definitions of a healing environment and well-being and/or in describing how they created a healing environment. They acknowledged spiritual care as more than an occasional helpful intervention. It was apparent to the researcher that spirituality was like a deep reservoir, whether in nurse, patient, or both, which undergirded all care given. It was important for affirming the patient as a unique individual who deserved respect and dignity and was an essential for infusing hope and courage for nurse and/or patient and family. While spiritual assessment often happened in the earlier phases of this model, spiritual intervention usually surfaced at this juncture of seeing from the nurse's point of view and partnering with the patient. Further discussion of this reality is offered at the end of this section.

The following three patient situations illustrate a shift in approach needed to partner with the patient. First, a fragile, very sick, elderly man in ICU did not want to make any treatment decisions without his family. When the family showed up on her shift, the nurse quickly arranged a family meeting with the patient, treatment team doctors, and herself. Now, with family involvement in decision making, the weight of these decisions was removed from the overwhelmed patient, and he could focus on cooperating versus resisting. Second, a drug-seeking patient realized pain medication was not her primary need; what was most needed was to learn how to trust herself and others and express her needs in words. Third, the cardiac nurse realized that a diabetic cardiac patient needed to trust (versus having to defend himself against) the nurse and the team to learn how to better manage his diabetes and avert frequent trips to the hospital.

The nurse is, most often, the one who initiates this shift in approach and can then formulate new goals with the patient. These specific goals toward well-being must be formed in partnership with the patient's uniqueness in mind. In other words, the patient's goal, "what the patient would like to accomplish," must be realistically matched with what is desired and possible for the patient. What is the best potential for this particular patient? Otherwise, pursuit of those desired outcomes may be thwarted. Subsequently, the healing path becomes recovery of lost momentum or lost ground.

Nurse Exemplars

In the care scenarios which follow, advocacy and vulnerability were two of the 120-plus open codes generated early in analysis. The readiness factor appeared as an open code in later interviews, and none of these three were the original seven substantive codes. As analysis progressed to identification of concepts within the data that explain

how substantive codes are related (selective coding) and how all concepts relate to the core category (theoretical coding), a memo sort was done and comparison made to the most recent version of the conceptual model—“charting the healing path.” It was here that advocacy, vulnerability, and a readiness factor emerged as significant mediators in moving into partnering with the patient. Seeing these modeled in the nurse exemplars that follow provides insight into how data at the conceptual level emerges to inform development of a substantive theory.

Elderly ICU Patient

The following patient-centered care scenario illustrates the matching of the patient’s goals with his best potential for this day. The ICU nurse identified a potential threatening decline of her elderly patient if the patient’s cooperation, pain, respiratory, and nutrition issues were not addressed immediately. This patient did not want to make decisions without his family being involved. When they were available on her shift, she quickly facilitated a meeting with the care team (doctors, nurse, patient, and family), and the patient started cooperating with some of his cares.

A pain team referral and intervention made it possible for him to get the computerized tomography scan (CT) which diagnosed a pulmonary embolus. Until this point, the issue of pain control had obscured the deeper issue of anxiety about breathing and a fear of dying. The nurse was pushing for continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BIPAP) because the patient would desat to 83 or 79 when the team goal was 88%, on a non-rebreather, 100% O₂ mask. The nurse, present to the patient’s distress in taking five minutes to swallow one pill, was insistent with the physicians, but they were not there to see, to observe, or to know. In retelling

this story, her usually quiet and calm voice became louder with urgency and intensity.

She stated:

. . . I told them he probably needs CPAP or BIPAP. . . . It was all oxygenation issues, and I kept pushing them. “I think he needs to be on CPAP,” and they kept trying to push him to be downgraded. He’s on 100 % O₂ and they wanted him on high flow nasal cannula, which would have given him maybe 30 to 60 % and I was, like, ‘he’s not going to tolerate that.’ And they kept saying, “Well, if he fails then just put him back on the non-rebreather.” And I’m, like, “Well, why do you want to do this to him if I already know he’s going to fail?”

This nurse literally said, “Thank you Jesus” when the physician finally gave the order for a CPAP with a setting of 10, and “within five minutes we had his oxygen FIO₂ down to 70% and he was satting, like, 95.” She was very grateful to have made such a difference in his care that he could finally rest and get oxygenated. “. . . By the end of my shift he was in sinus rhythm. I felt very, very grateful for all of the things, and I actually prayed with him . . . three times during this day.” She recounts that, in the midst of being very anxious about dying, he would grab her hand and say, “Give me a prayer. Give me a prayer.” She would pray and he would calm down and breathe easier. By the end of the day, “He was telling me ‘You saved my life. You saved my life.’ It was very rewarding. We had come so far in that day.”

This intense day illustrates the nurse’s skill in advocating, first with the family, because that was what the patient needed to move forward and begin to cooperate. Next, she was pushing the patient to go for his CT and to be willing to get a new percutaneous infusion catheter (pic) line. Each time he would decide to partner with her because a trust was building as he knew his needs were being addressed. Then, she had to advocate with the team of physicians, pushing for his oxygenation issues to achieve better outcomes. She was correct in hearing the patient’s immediate concerns and his perception of pain

and fear and anxiety. He also needed reassurance from the doctors that, because of his age and the type of surgery that he had, complications were to be expected. Upon hearing this reassurance from the team, he experienced the nurse helping establish realistic goals for his best outcome. The healing path evolved throughout the day because the nurse could match the patient's physical condition with what he needed emotionally and spiritually. By the end of the shift she was "out front" reminding him of the fighter she had already seen in him and how it was obvious he wanted to recover. She identified this infusion of courage as an important next part of his healing path because ahead of him was chemotherapy and a rough road to recovery. She stated, "we want [an] 'I can fight this' outlook . . . and I think that's what will keep him alive. So, I talked to him about that kind of outlook right now . . . 'stay positive and we can do this together.'"

For this nurse, spirituality was never primary, but it was a powerful source of comfort and assurance that calmed the patient's whole being for some time. Both the patient and the nurse were changed by this intervention. Previously, she primarily "prayed internally" [quietly to herself] for her patients and asked God's wisdom and guidance for the entire care team at the beginning of the day. But, this patient initiated the request so assertively "Give me a prayer. Give me a prayer," that she could hardly refuse. Demonstrating her vulnerability, she hesitantly prayed. She remembered wondering what she would say and was amazed that the words just came. The second and third time she was much more at ease and it seemed a seamless intervention. It became yet another way she advocated for the patient and established a partnership. The difference was, this time, the patient was in the lead and she was responsive. Her

readiness factor was demonstrated as she did whatever was necessary and marshalled all the empiric and spiritual resources at her disposal.

An Interrupted Healing Path

The young cardiac nurse, whose expertise had earned her the status of preceptor for new nurses, gave an example of partnership gone awry. She sensed the patient's wife being distressed from the moment of introduction when the orientee was giving nasogastric (NG) medications. For some reason the feeding tube clogged. After many attempts to unplug the tube, it had to be pulled and reinserted. Assessing the situation, the nurse discerned the patient and wife were very unhappy and not in a mood to partner. The orientee was also feeling pretty low. The nurse stated, "I was thinking, what could I do to better this already bad situation." Knowing the orientee needed to learn and grow, not be taken off this patient assignment but have a little distance, the nurse "pulled other nurses who had worked with this patient prior [sic], who knew the family personally." Two of the four had successfully put in an NG tube for this patient the previous week. Near the end of the shift, in a four or five minute interaction with the wife, the nurse apologized, assessed the wife's spiritual beliefs, and affirmed God was still in control to which the wife whole-heartedly agreed. It was then she and the wife hugged, and "we were able to come to some type of reconciliation, maybe some type of healing." This nurse's advocacy was to act on behalf of the orientee, the patient, and his wife. She also secured involvement of trusted care providers. She accepted her role as the one responsible for any errors in care, apologized, and communicated her desire to reaffirm God is in control. The wife responded very positively to her vulnerability and readiness to bring both hope and closure.

The expert assessment and attitude of service of the preceptor, plus great teamwork and peer support from four other unit nurses, made recovery of trust and partnership possible. This recovery became the healing path toward well-being.

Realistic Goals

Once partnership was identified as a substantive code, it was seen to have goals as part of it, but it was later interviews with KK, LL, and NN that identified the two separate categories contributing to partnering with the patient. The first was setting realistic goals; the second was facilitating their best potential. As previously stated, realistic goals must take into account the patient's best potential and how it can be achieved.

The following situation illustrates both the short and long term realistic goals that nurse-patient partnerships must address. In the emergency department (ED), nurses have to be masterminds of kindness, discernment, and rapid response that communicate availability and building a partnership toward well-being. One male ED nurse (LL) described a middle-aged woman admitted with chest and abdominal pain whose makeup was immaculate. After a brief introduction, and with a twinge of humor, he asked what time the patient had to get up to "put on your face?" She laughed and, without batting an eye, said, "Four-thirty a.m. At least I couldn't sleep," seeming to imply that she might as well get up and do something positive. It was then he noticed that she was shivering. Chest pain protocol of starting the 12 lead EKG, initiating an IV, and drawing labs was averted a few seconds in order to get heated blankets. Now, all procedures could be done under warm blankets. He then told an impressive story of "scaffolding with her" and her husband to ensure their partnership in all the care planning from where the IV should be, to getting coffee for the husband, to explaining neurological assessments before and after

the IV pain med, to indicating a good time for the husband to go to the cafeteria for food, etc. Hearing the patient's and husband's immediate concerns, addressing those, and setting realistic goals for pain relief created the healing path for this patient and her husband. This plan, forged together, allowed the patient to rest and the husband to relax while awaiting "what's next." Ultimately, she was briefly admitted with a plan for addressing the pain from renal calculi.

Not all partnership and goal setting are of this complex nature. Sometimes it's straightforward, at other times it requires negotiation, and sometimes nurses must be a master of finesse. Whichever approach is used, the nurse needs to hear from the patient and validate what the patient perceives as important before establishing a plan of action. Nurse EE related the straightforward approach by hearing how the patient was doing, and then asks, "What [do] they want to do that day, . . . then, from there, bring in our expectations as well. Just sort of be on the same page of what it is they want to accomplish that day." Sometimes it is negotiating. For example, when can the patient move from using the bed pan to getting up to the bathroom? One nurse (DD) stresses how important to explain the rationale to the patient: "I don't feel safe with you getting up. Did you see when we turned you, you could barely breathe? . . . Your oxygen level went really low." She emphasized to the patient this was a temporary thing until the patient was better. A nurse (GG) floating to another unit was assigned a combative patient with a history of striking out at the nurses, the sitter, the doctor, etc., and had to patiently finesse the patient's cooperation. Primarily, she explained to the patient what was needed and asked the patient's permission for every step of whatever procedure or task was at hand. In order to do blood draws, the nurse asked permission,

is it okay if I hold your arm down? And she said, ‘Yes.’ Is it okay if he holds your arm down? . . . She goes, ‘Yes.’ . . . A little bit of a control . . . and we were able to get everything done.”

One intensive care nurse (KK) summarized the partnership nurses must develop with patients by saying, “. . . we need them to be active participants in their care . . . when we have mutual goals we can work toward them being discharged and . . . being managers of their own care.”

Realistic goals are best if they are desirable, possible, and equip the patient and/or family to better manage specific care needs with their best potential in mind. A male ED nurse (LL), floating to a medical /rehabilitation unit, engaged the “helicopter wife” of many years to be the feeder of her husband, a recovering stroke patient. The nurse explained his choices. He could (a) give the patient a couple of bites, say his swallow is not intact, and recommend an NG tube, realizing this is not best for the patient, nor does it address his potential; or (b) engage the eager-to-help wife who loved serving her husband. He explains:

She was able to feed him the whole thing . . . after a few bites I could tell that he was doing a great job. I didn’t have to stay there in the room, so that helped me go to another patient, and I could peek in on them.

Facilitating Best Potential

Changing the Landscape

Goal setting often requires establishing new awareness or reawakening desire in the patient to engage in something enjoyable. Changing the landscape of “the possible” allows the best potential to surface in a manner which can motivate the nurse, patient, and family to work together towards that goal in tangible ways.

This process was demonstrated by the nurse (NN) who realized the post cardiac surgery patient was very depressed (not uncommon) even after a psych consult and starting antidepressant medications. Yet, no one had identified what motivated the patient, what would motivate him to get out of bed. This nurse began to talk to the patient and finally discovered he wanted to play golf again. Fortunate for this nurse and patient, the patient's room had a view of the beautiful golf course right across the street. The nurse stated, "So, I told him, if you really want to play on that golf course, the only way that you can do it [is] for you to get up. There's no other way. You can't do it in bed." Step by step the nurse changed the landscape of the possible. He did this by (a) opening the curtains (patient preferred them drawn); (b) cajoling the patient with humor, "Much as I like you, I don't want to see you in here anymore"; and (c) employing the wife and physical therapist (P.T.) in getting the patient to sit on the edge of the bed. The nurse, with the help of the wife and P.T., helped the patient to begin eating his meals in the chair, established the goal of walking to the nurses' station, and soon found the patient staring out the window at the golf course. It was then that the nurse knew he was effectively partnering with the patient in his desire to heal. Notice the nurse had to take the lead in setting small stepping-stone goals with the desired and realistic goal of playing golf again. The patient would not know how to progress through each of these steps on his own. Rather, trusting the nurse, the patient willingly partnered the intermediate goals, moving toward healing and well-being. The nurse evaluates this process, saying:

I think what helped a lot is having that knowledge of knowing your patient and really getting in touch with what they like and what they want. And what motivated [him] helped a lot with getting him up and getting him better, and healing.

The patient's best potential most often gradually reveals itself in the midst of what is meaningful to the patient and securing the patient's agreement with the goals of today, not necessarily with a full view of all the goals necessary for discharge. Often, changing the landscape of the "possible" to set mutual goals with the patient's best in mind requires the nurse's advocacy with underlying social and/or emotional realities that are easily missed.

One nurse (OO) illustrated a readiness factor in taking initiative to confront a patient that was being inappropriately negative with the unit secretary. By speaking construction language to this former general contractor (that which was meaningful to him), getting his agreement about the wisdom and importance of delegating the small jobs, and overseeing the big picture himself, the nurse could effectively confront his rude behavior. He stated:

Okay, then why are you yelling at her [the unit secretary who answered his call light, etc.]? She's trying to help us out. Why are you treating her bad? She's running the small job and I'm trying to run the [big] scheme of things and you're yelling at her! And he said, "Oh, well, I never thought about it like that."

Theurse indicated the patient did apologize, but the behavioral change was short-lived in that it reappeared with the patient's next admission. However, currently, this nurse was able to secure the patient's partnership with the goal of accepting versus rejecting the help of multiple care-givers until discharge. Another nurse (BB) echoed that the patient's story "... unfolds throughout the day. . . . That's where you can discover, 'What is it that I can do to help this patient?'" An ED nurse (LL) offered that facilitating "the possible" often means breaking down large goals into smaller steps. He emphasized it is important "that the patient somehow have little goals, feel like they're winning a little bit each day . . . it's important . . . to really discuss, re-educate, re-focus, and re-

group the patient and their family.” These smaller goals achieved contribute to the development of the positive, self-management attitude and understanding.

Self-advocacy and Self-management of Care

The nurse, with the patient, identifies what needs to be further developed in the current situation in order to achieve the patient’s best potential. One nurse (NN) termed this as “their next level of health.” He described this next level of health as assisting the patient to become “independent, knowing what they need to know to actually take care of themselves and be healthy in terms of what their goals are.”

One nurse (KK) reminded an orientee that, with chronic pain patients, “. . . we don’t go in with any preconceived notions of this. So, we need to make our own judgment about what’s going on and help facilitate the best we can.” Steps toward developing this judgment involved letting the patient wake up from the previous pain medication dose to assess the patient’s perception of chronic pain. Additionally, the nurse wanted to know how effective the current strategy was at meeting not only her pain needs but also the as-of-yet unidentified goal(s) of returning home. After listening to the patient and hearing her talk on the phone with her husband, it became clear that taking care of her children at home with an acceptable pain level, until her husband returned, was the realistic best potential for this patient. Then, she could plan her return for the needed surgery. The nurse summarized this process and added the goal of self-advocacy and self-management of care, as illustrated in the following:

. . . so not having that judgment, assessing the patient’s needs, and working towards mutual goals keeping them involved [while] being a patient advocate, . . . definitely having them be[come] advocates, promoting health, advocates for their own health, and education ‘cause a lot of times they need that reinforcement to help them manage their own well-being.

Thus, being managers of their own care was one of the outcomes nurses observed when patients are realizing their best potential. Connecting the patient's baseline with the desire to return to life outside the hospital helps establish what is realistically possible.

Outcomes Seen or Observed

In open coding, outcomes was a category from the first interview onward. Open codes were not listed under outcomes. Rather the narrative descriptions were coded as outcomes, and analysis yielded the positive response-consolidated categories described below. It was in selective coding that facilitating their best potential surfaced as an aspect of partnering with the patient. In the final memo sort, *realizing their best potential* surfaced as an outcome. Nurses listed many along-the-way outcomes that signaled positive responses to "charting the healing path". These have been categorized as (1) physiological and emotional indicators, (2) change in the patient's perception, and (3) self-care knowledge and management.

Physiological and Emotional Indicators

As nurses see patients achieve their best potential, there are many outcomes which accompany this category. Nurses identified physiological measures such as BP, FIO2, respiration and heart rate as stabilizing. The emotional indicators included the patient relaxing, falling asleep, needing less pain meds, and enduring treatments previously refused. Nurses reported that when anxiety decreased, some patients would become more interactive, have a return of humor in their communication, and often have fewer requests for nurses. Many times, patients and/or their families would give verbal or written thanks or comment on how helpful the nurse was. It was not uncommon to see patients, nurses and/or others in the room cry and patients and/or the family share, open

up, and “unload a gamut of things.” Multiple nurses mentioned peace as an observable outcome, whether peace in the patient’s “countenance - being more at rest,” or “peace came into our hearts and into the room and God’s presence was there.”

Change in Patient Perception

Another category of outcomes is seen when confusion is replaced with understanding, or when resistance changes to cooperation and a more peaceful way of being follows. This change happens as a result of education: timely, sensitive, and often repetitious instruction regarding what just happened, or is about to happen, for the patient and their care trajectory. One nurse (II) stated, “. . . you’ll see it because you’ll ask them, ‘Can you review what I just went over with you?’ And, that’s the way you know that they are learning.” Behaviorally, when the patient’s attitude went from “. . . nobody understands me. I can’t deal with this [pain]” to acknowledging her realistic pain goals were actually met, the nurse knew the patient had overcome her emotional barriers and was able to hear much of what was being taught. This progress readies the patient for the next steps to discharge, which requires yet more education. Self-care strategies can be taught, reviewed, realigned as needed, and finalized. Now, it is timely to reflect on the nurse’s spiritual assessment and intervention as woven into the final phases of “charting the healing path” model.

Spiritual Strategies Integrated in Partnering With the Patient

Nurse Initiative

The researcher’s concern was to identify strategies nurses used to create a healing environment and enhance well-being. The nurses expressed concern that the main problem they were trying to solve in creating a healing environment was “helping them

[the patients] get better.” The behaviors they used to solve this main concern were conceptually mapped into the “charting a healing path” model. The researcher did not ask about spirituality or spiritual strategies unless, by the end of the interview, the nurse had not mentioned anything about her faith beliefs or commitments. With one exception, every nurse initiated discussion of spiritual strategies as behaviors they used to create a healing environment. With this one nurse, the researcher posed the question, “What is your spiritual or faith-based background, and how do you express this in creating a healing environment that enhances well-being?” See Table 5 for open coding and the consolidation of codes into spiritual strategies. These spiritual strategies make up a reservoir that is aligned with whole person care as background context, not as substantive category, of the “charting the healing path” model. Because of the sheer volume and number of exemplars shared in explaining their behaviors to create a healing environment, this researcher determined it helpful to analyze how these Christian nurses used these strategies to create a healing environment.

Spiritual assessment occurred during the baseline assessment and throughout the nurse-patient interaction. The timing of the spiritual intervention most often occurred at the juncture of two categories: seeing from the nurse’s point of view and partnering with the patient. This finding suggests that the nurse’s personal faith and spiritual practices are an important source of knowledge and resource for partnering with the patient toward well-being.

Context for Provision of Spiritual Care

Both institutions where these Christian nurses worked held spirituality as a foundation for whole person care. Therefore, no nurse felt censored or intimidated in

responding to patient's spiritual needs. With one exception, each nurse modeled awareness of his or her own spiritual beliefs and recognized belief in God as a resource to being a compassionate care-giver. At differing points this awareness enabled them to extend that resource to patients via their care. The nurse who was an exception (GG) mentioned, in passing, that she had a faith background, commented about no longer attending church, and said nothing about this faith being integrated in or important to her daily nursing care.

Nurses Accessing their Faith Reservoir

Nurse spiritual beliefs and practices in "charting the healing path" involved a deep respect of the nurse's own and the patient's spirituality. These nurses verbalized accessing their faith and trust in God throughout the day. Several nurses talked about praying as they began the day, as they drove to work, crossed the parking lot, and entered the building. They were asking God's help in how they readied themselves to face the day. Others spoke of prayer connected with getting their patient assignment and before going out to the patient area. ". . . And we pray about our doctors and our patients and that we can make good decisions and [*sic*] regarding their care" (KK). For Christian nurses with a strong belief and practice of faith, this quick prayer at the beginning is just that: a beginning of the day's adventures in accessing their spiritual reservoir. Whether starting an IV other nurses were unable to initiate, or after getting it started, this nurse (AA) insisted she was ". . . praying the whole way [to the patient's room], and even when I got down there . . . I was saying to myself, 'All things are possible with God, so you got to help me with this IV, God!'" After she got it in, she said out loud, so the patient could hear, "Thank you, Jesus. . . . It was important to give glory to God, to acknowledge he

helped me start that IV.” This “out loud” thank you reflected the nurse’s follow through in her relationship with God and was, secondarily, a possible conversational opener if the patient chose to respond. The patient did not and the nurse was simply thankful for God’s help in her nursing care.

Spiritual Assessment

In the midst of the strong faith and understanding of a personal God actively involved in their nursing care, there was a great variety of assessment strategies and intervention to meet a patient’s spiritual needs. Least mentioned was spiritual assessment on admission via a checklist of routine questions. One nurse limited assessment to the admission checklist, or if the patient “. . . takes a turn for the worse . . . then we offer more” (GG). Additional ways these nurses did spiritual assessment are given below.

Routine Spiritual Assessment Practice

A master’s prepared nurse (BB) assessed every patient on her first day of caring for them with, “Do you have any spiritual beliefs that would play a part in my care for you today?” She also prayed for opportunities to supplement her assessment if they answered negatively and to speak further about their interest in knowing Jesus. Examples of these additional questions included “What’s going on in your life that impacts your ability to heal and rest while you’re here in the hospital?” and “Do you know where you’re going when you die?” She continued, “And if they don’t, I’ll tell them they can know if they are interested.”

Conversing with the Patient

What was more common was conversing with the patient “to try to find where they’re coming from” (FF). This conversation included questions about tattoos and their

meanings, family, culture, traditions, and “kind of reading the patient and understanding what is going to be helpful for them” (CC, JJ, PP). FF explains that sometimes she simply strikes up a conversation with the patient “. . . without any forethought, and then it just unfolds and all of a sudden you’re getting into the meat of the matter. And before you know it, they’re opening up and telling a lot of personal stuff.” The dynamic nature of the healing environment means the nurse must be intentional about hearing and acting on this deeply personal information. As nurses listen, they are able to discern what matters to the patient, and, if wholeness is lacking, if something is missing, they can sensitively assess and question the patient for more healing information. Assessment conversation also gave patients a chance to think and talk about “. . . what their support is . . . their background, and what helps them” (PP).

Nurse’s Observation

Nearly all nurses indicated they were comfortable with spiritual assessment questions, but six nurses reported their assessment was more commonly based on observation of patients’ rooms and behavioral cues that spirituality was important to the patient. These same nurses often waited until the patient brought up the topic of spirituality, except on certain occasions of patient distress or discouragement. Then, the nurse would ask, “Can I pray with you?” Interestingly, the Pentecostal nurse was very careful not to push personal beliefs on other people. Though he willingly prayed with patients who asked him to do so, he only occasionally initiated that request to pray whether with staff or patients.

Spiritual Intervention

Follow-up to Assessment

One of the VIP nurses (BB) (selected by unit managers to meet spiritual needs of patients, staff, and families) related stories of rather extensive spiritual assessment done with every patient to address spiritual concerns or needs. When doing her morning assessment of the spiritual beliefs of a 93-year-old man who had attempted to commit suicide, he had indicated he had no spiritual beliefs. Later in the day, she asked if he knew where he was going when he died. “No.” But, he indicated interest in learning how he could know. This nurse offered to share the plan of salvation and to pray the sinner’s prayer with the patient to receive Jesus as his Savior and Lord. The patient gladly accepted and prayed this prayer. After she finished and went to the other patient in the room, he promptly said, “I want to do the same thing that you did for that man.” She had thought her conversation with the first patient was so intimate and quiet that she was surprised, yet jubilant, that the second patient had heard. Some nurses would have concern that this approach would be perceived as proselytizing and offensive. However, in this situation one patient was offered the intervention and accepted while the second patient seized the opportunity to ask for and receive the intervention. This nurse’s care was patient-centered, and she appropriately screened her patients for their interest in learning more about Jesus’ love and plan of salvation.

This same nurse reported a situation where a patient was offended and complained to the charge nurse after being asked the “Do you know where you’re going when you die?” question. The charge nurse explained the nurse was doing her routine spiritual assessment, that she asks those kinds of questions to help patients with spiritual

needs. At that point, the nurse walked into the room, entered the conversation, and apologized to the patient. She had intended no offense or ill effect and took special care to be attentive for the remainder of the shift. The nurse reflected, “I’m pretty good at conflict resolution, and so I think [that] played a part in it, and God just allowed me to show Him in a different way, ‘cause it’s not always going to be verbal.” By the end of the day the patient apologized to the nurse, and the nurse-patient relationship was deepened by having experienced conflict resolution.

Intervention from the Nurse’s Faith Engaged

Few nurses are so thorough and consistent in this depth of spiritual assessment as portrayed above. More often, nurses described spiritual intervention happening when the patient situation was deteriorating, or the nurses did not know what else to do when the goals for the patient’s best were not being achieved. The following examples suggest the nurses needed to have their own reservoir of faith engaged, and, once that happened, it became a ready resource for the patient who accepted the offer of nurse intervention.

Nurse-patient Examples

A cardiac nurse (DD) recounted the patient who was rapidly worsening, and the options were few. What the man needed was a new heart, but that was not yet available. This nurse was the resource nurse. She, along with the primary nurse in consultation with the team doctors, had tried many things without a positive response in the patient. The patient was slumping over the bedside table, and the wife, crying, was holding the patient. “In a moment of complete helplessness . . . I just said ‘Do you want to pray?’ . . . that’s all I knew to do.” The wife answered affirmatively and nurse, patient, and wife held hands while the nurse prayed. The nurse reported,

in that moment, peace came into our hearts and into the room and God's presence was there. It was just such a beautiful moment that it was just like time stood still. . . . 30 seconds later I said, 'Amen.'

Immediately, the hustle and bustle of starting new drips, trying new meds, and running around resumed. But, at day's end, when the nurse was leaving, the wife caught the nurse in the hall and said, "Your prayer changed the day." The nurse continued, "And the very next day I wasn't at work and he got his heart. It was incredible." The nurse said, "I knew they believed in prayer and God because they answered affirmatively when I said, 'Do you want to pray?'" She had not done spiritual assessment with this patient, yet her intervention flowed from her own deep conviction that God was with her and a powerful resource of love and care. "I feel like He is teaching me through that, 'I'm all you need in your time of distress.'" She acknowledged how easy it is in critical moments to forget about God and get caught in a flurry of activity. "But it takes thirty seconds to connect with God and it makes the world of difference." The primary nurse shortly after that prayer told her, "I'm glad you prayed with them; that helped me and gave me peace too." The nurse affirmed the greatest blessing of joy is hers in situations like this where, "He allowed me to be there at that time."

Another nurse (FF) shared one way God has routinely used her in just a few minutes of time. She anticipates there may be a patient with whom she is to share the truth of Jesus and his great love. Often, though not always, she senses these patients are prepared to hear and receive this good news. Sometimes this was a patient of a different faith or without any particular faith decision: sometimes a person with religious background but who had never made a commitment to Jesus or seemed to have lost that commitment along the way. She described being alert to which patient might be the one

with whom to share the good news of forgiveness in Christ. Though she was articulate and bold once she knew who the person was that God had readied to hear His message, she acknowledged there's no formula to this approach. "It's hard to explain. I wish I could give everybody the ingredients of how it works." One interaction of this type follows in her caring for a young, 19-year-old Hispanic man, a drug kingpin with bullet holes all over. He had FBI and Correctional patrol at the bedside and was headed to jail for a long time. The nurse shared:

I thought to myself, 'I have to do something . . . this kid will think about for years to come. So they brought in the orange jump suit, and they were suiting him up, and I put my hand on his shoulder and said, 'Let's pray. Is it ok?' and he said, 'Yes.' . . . I was praying . . . I approached him from a 'we' standpoint. I said, 'You know we all fall short of the glory,' and I went through this prayer with him. At the end I looked down at him and there were just tears coming down and I looked at all the officers and their eyes were all welled up, as well. And, I knew I had seized the moment and made an impact that he was going to think about, and he'll always probably remember that.

The Contrary Case

Again, some of the nurses interviewed in this study would be uncomfortable with this kind of initiative in sharing God's love and desire for relationship. One nurse (NN), in particular, though Catholic and with a strong spiritual care ethic of demonstrating faith, hope, and belief, resisted ever talking about religion, letting the patient know he was Catholic, or that he possessed a strong faith. He almost never offered prayer with patients but described two times he had prayed. Both times, the patient asked him to pray, and he did pray because he believed it was important for these particular patients healing. There was no question his nursing care communicated dignity and respect, knowing the individual as a unique person worthy of love and care, and belief in the patient's ability to receive light and love necessary for healing. His resistance came from

experience of religion as divisive and awareness that his talking about God or Jesus could be offensive to someone who did not believe. He believed he could communicate all the positive attributes of light, love, and healing power by actions versus needing words to explain. This, as the contrary case, is one that stands in stark contrast to the other nurses interviewed.

One of the more seasoned nurses (FF) shared one situation of how she intervened with patients who were sharing spiritual stories with each other. She overheard the conversation as the two patients were discussing their past personal tragedies and current health issues. Each perceived that they could not have successfully dealt with the other's challenge, and, with the help of the nurse, they concluded, "God will not give us anything we cannot handle." Each was gaining strength by listening to the other's story and appreciating the difference. The nurse recognized their sharing about spiritual realities as part of finding each patient's best potential. Her contribution was to highlight how both of them were able to focus primarily on God and his action in the situations in front of them rather than solely on the circumstances. This support was especially true for the patient with a mending broken hip who was facing several weeks of rehabilitation before her return to a challenging care-giver role at home with her debilitated husband along with her beloved horses. Hanging on to this spiritual truth of focusing, trusting and depending on God in the midst of challenging circumstances was going to be part of this patient's longer-term view of health and well-being. It would be essential to her best potential now and in her post-hospital portion of recovery.

Privilege of Being Used by God

Several nurses spoke of the privilege of being with patients and being used by

God to touch them: to be the hands of Jesus caring for these patients. One nurse stated that in caring for her most vulnerable patients who “can’t speak or who are severely limited,” in caring for them she was “. . . caring for Jesus. And, I ask Him to help me care for Him, ‘cause they’ll know love if I’m really caring for Him.” Several nurses (AA, BB, CC, DD, FF, KK, OO) spoke of the privilege of caring for people in their time of need, of being used by God at this time, of being an instrument of God. One nurse commented, “It’s a privilege to make a difference and to be able to be used as an instrument of God and it’s an honor, it’s really beyond words how it makes you feel.”

Passion and Purpose of the Nurse

Two nurses (AA and DD) explicitly mentioned the sense of purpose and calling one has as a nurse, and others implicitly gave comments to support this idea. The first nurse interviewed connected her personal passion with her nursing practice: “I am passionate about this. . . . this is what I’m meant to do. This is where Jesus lives his life through me. This is where people meet Jesus in me.” She acknowledged she does not always get to give verbal spiritual care but sees the birth of a new baby as an opportunity to raise spiritual awareness through the miracle and beauty of birth. She used phrases such as “this baby is a gift to you,” “God does good work,” or “we are fearfully and wonderfully made, that’s what the Bible says.” Another nurse revealed that she switched majors from theological study to nursing because she was really interested in helping people get better in a more “hands-on” way. Nursing as ministry is what these nurses are talking about though none used those exact words to explain their practice.

Conclusion of Spirituality Findings

These stories of accessing spiritual strength and hope surfaced most frequently

when relationships of trust were established and partnerships toward healing were being formed even if in only one shift of caregiving. Sometimes it took the sense of “no longer knowing what to do to help the patient get better” to remind nurses of their own spiritual resources. Then, they could readily access those resources. Thus, spiritual care giving has no identified box in the “charting the healing path” model. It is present as the individual nurse’s underlying reservoir, consistent with the whole-person care contextual focus within the institution. This faith reservoir was, therefore, readily available to the nurse and/or patient who trusts that God is present in all aspects of creating a healing environment.

Nurse Characteristics

These Christian nurses exemplified a faith-in-action characteristic and were aware that words were not always necessary or appropriate to communicate the reality of personal faith commitments. All but one acknowledged their own faith belief and commitment as central to their ability to give spiritual care.

Based on their Christian commitment, they were also compassionate caregivers. Being willing to walk with the other in his or her suffering and withholding judgment characterized their interactions with patients and staff alike.

Another characteristic was their positive attitude and outlook. This outlook was demonstrated by concern they offered the patient their best and did not bring personal problems to work. Many spoke of being encouragers, of giving both nurses and patients affirmation which they perceived as enhancing the healing environment.

Only one nurse had a reflective practice of writing patient exemplars as a method of focusing on how God used her and gaining courage to keep on offering patient-

centered spiritual care. However, almost all the nurses interviewed indicated having time to reflect as the greatest benefit of participating in this research. As one nurse stated, it was encouraging to reflect on “all the things we do to make a difference” in the patient’s recovery of health and well-being. Several voiced the desire to do this on a more regular basis.

Being intentional was characteristic of these nurses as they demonstrated being organized (clustering their patient interventions to allow time for quiet and rest) and patient-focused (clear about the patients being central to all their actions and efforts). Many of these nurses incorporated some aspects of the external dimensions of the healing environment (quiet, lighting, space, etc.) in care given. But, all were strategic and intentional about utilizing themselves and the nurse-patient relationship to chart a healing path for their patients.

Half of the nurses verbalized self-care as an important strategy for their ongoing ability to create a healing environment. Though no data was gathered regarding actual self-care practices, the visual appearance of these nurses demonstrated a commitment to balancing caloric intake with bodily demands. Nurses mentioned journaling, processing with friends, exercise, hobbies, getting enough sleep and other rejuvenating activities as aspects of self-care in which they regularly participated.

Conclusion of Findings

From the initial sense of helping them get better to partnering with the patient to set realistic goals for facilitating their best potential, the nurse was a central figure in strategizing how this healing environment would be created. For these nurses, *charting the healing path* emerged as the core category by which they answered their main

concern of helping the patient get better. Though “charting the healing path” changed throughout the care process, the desired outcome of realizing the patient’s best potential (or movement in the direction of it) was consistently achieved when the nurses’ knowledge of self and other care resources were used to partner with the patient toward healing and recovery of well-being.

CHAPTER FIVE
DISCUSSION, IMPLICATIONS FOR FUTURE RESEARCH,
LIMITATIONS AND CONCLUSION

Nurses in this study described their main concern in creating a healing environment as “helping the patients get better.” The behaviors used to solve this problem were, in data analysis, conceptually mapped to move from helping them get better, to fostering the healing environment, to charting the healing path. In this grounded theory study, *charting the healing path* emerged as the core category. The substantive codes in the model began with (a) assessing the patient’s baseline and (b) being available to meet patient needs, and then proceeded as the nurse focuses on the following: (c) knowing the patient as a unique person, (d) hearing the immediate concerns, (e) seeing from the patient’s point of view, and (f) seeing from the nurse’s point of view. At the intersection of the nurse and patient points of view came (g) forming a partnership toward well-being which results in (h) setting realistic goals toward (i) facilitating the patient’s best potential, and (j) observing outcomes. All of these occurred (k) in the context of whole person care.

Charting the Healing Path

What nurses have said in the “charting a healing path” model about creating a healing environment is located in the client-health interaction domain with nursing having input in that interaction and its consequent outcomes. See Meleis’s (Meleis, 2007) concepts central to the domain of nursing. The environmental essentials detailed by these nurses are both implied and supplied.

Implied essentials surface as the nurse focuses on the nurse-patient interaction. This finding is supported by decades of theory development and research on care and the caring work of the nurse as central constructs of nursing (Benner et al., 2009; Benner & Wrubel, 1989; Erickson, 2007; Swanson, 1993; Watson, 2001, 2008). Nurses explained that “charting a healing path” involved a partnership with the patient: a moving toward and creating a sense of ownership of and will-to-health. This ownership and will-to-health was a mutually interacting process with the nurse taking the lead, sharing it, and eventually transferring this will-to-health to the patient. This process highlights one of the theoretical codes which apply to this research, the interactive family, where nurse and patient engage in a mutually interactive commitment of changing degrees to the healing path outcomes. A slow-motion, time-expanded handoff of the relay race baton is an image which captures the process elements of “charting a healing path.” The nurse begins the run holding the baton, knowing the patient, building the partnership and getting ready to transfer the baton of self-care to the patient. A successful handoff is essential if the second runner, the patient in this case, is to continue the race. In this research, the successful handoff was evidenced by setting realistic goals and facilitating best potentials. Realizing those best potentials happened as patients gained self-care knowledge and assumed self-care management. Thus, the patient continued the run.

A second theoretical code which applies to this research is that of the strategizing family. Glaser (1978) suggests the use of this code must have an intention, “a conscious act to maneuver people” (p. 76), in this case, intentionally moving patients toward facilitating best potentials. In doing so, these nurses understood this relationship of

privilege and trust as essential to the patients' movement toward self-care knowledge and management, thereby realizing their best potential.

Supplied essentials of a healing environment refer to “other-initiated efforts” toward healing. These nurses reported leaders or administration within the institution taking the lead in supplying external programs to support healing. Nurse recognition of these were, most often, deemed helpful and embedded in patient exemplars. A shared property of these programs was infusing some aspect of nature (a healing garden, time and place to rest with dimmed lighting and noise reduction, therapy dogs) or processes which facilitated nurse-patient interaction (hourly rounding, bedside reporting, nurse zoning, I-care cards, key words at key times).

Knowing the Patient

Helping patients get better is the starting point for the nurse. While this goal initially seems vague and general, it parallels basic nursing care (Gasquoine, 2001; Zoinierek, 2014), which is establishing the nurse-patient relationship and completing the baseline assessment (Radwin, 1996). Nurse availability to meet patient needs, awareness of the physical environment that will contribute to the well-being of the patient—space and time for quiet, rest, dimmed lights, privacy, etc.--and assessment are ongoing throughout “charting the healing path”. These ongoing patterns coincide with Zoinierek’s features of time – “having time, taking time, spending time” (p. 7) – which affect knowing the patient uniquely. Zoinierek’s (2014) integrative literature review generated three general topic areas, “care, relationship, and expert practice” (p. 5), constituting knowing the patient. The first two of these, care and relationship, overlap with the strategies these nurses spoke of in creating a healing environment.

Nurse availability in this study was nuanced in two directions. The first was availability to meet patient needs and the second was availability for relationship. The latter encouraged knowing the patient as a unique individual. Attentiveness is a category in the historical caring literature cited above; for example, see Swanson's (1993) concept of being there, and, similarly, recent research studies of nurse-patient interaction and communication studies (Pfeiffer, Gober, & Taylor, in press) as well as person-centered care (McCance et al., 2011; McCormack & McCance, 2006). For these Christian nurses, their interest and focus on the patient as a unique individual and their intent to "chart a healing path" communicated that the healing environment was patient-centered.

Juncture of Nurse and Patient Points of View

Fostering the healing environment involved knowing the patient as a unique individual where hearing the patient's immediate concerns, understanding how the patient viewed the current situation, and learning what the meanings were for the patient informed how the nurse-patient interaction could address these concerns. One conceptual category highlighted in these nurses' process of creating a healing environment was "the nurse's point of view." The juncture of nurse and patient points of view meant the nurse bringing self (and all the resources of knowledge and experience) to interact with the patient point of view, then initiate and inform a partnership toward health and well-being. This blend resembles concepts present in Radwin's (1996) literature review of knowing the patient and in theories of nursing for movement toward health and well-being. The following four examples illustrate this intersection of nurse-patient perspective from a breadth of nursing theories: (1) Pender's Health Promotion Model (Sakraida, 2010) names interpersonal influence as a modifying factor in health promoting behavior/action,

(2) Parse's "true presence" of the nurse with the patient allows imaging of possibilities to become power for transformation and growth as cited in Mitchell and Bournes (2010), (3) Swanson's (1993) "effective knowing sets the potential for" partnership seen in being with, doing for, and enabling client progression toward well-being, and (4) Van Dover and Pfeiffer's (2012) concept of the patient being understood by the parish nurse opens the possibility for the patients knowing God's understanding of them and their current situation.

Bridge to Partnership

The nurse bringing self and his or her perspective to the patient was a bridge to partnership and proved a vital link for "charting a healing path." Halldorsdottir (2008) uses the bridge metaphor to highlight the power of a caring connection for healing from the patient's perspective. At this point, the nurse with all the attendant knowledge and background, clinical skill and judgment, and personal characteristics embodied care and strategized on behalf of the patient. Here, the nurse advocates for a healing environment and well-being, starting with the present and charting a way forward. As one seasoned master's prepared nurse said, "I listen a lot, and help that person discover what might help them heal." By listening, this nurse envisions the way forward and how the patient and/or family will be central in that healing path. Though described in different terminology, this idea compares with Lincoln & Johnson's (2009) nurse-healer role, which facilitates access to healing and to Broyles et al.'s (2008) implied roles of nurse as innovator and healer.

Knowledge and nurse-patient relationship become mutually interacting variables woven together with advocacy of the nurse and vulnerability and a readiness factor on the

part of patient and nurse. Gastmans (2013) describes the starting point of ethical care for the patient as vulnerability contrasted by the nurse's starting point as "concern about the vulnerable state in which a patient finds himself or herself . . ." (p. 147). This description is similar to the advocacy of these nurses as patients become known. But, in this study, the juncture of nurse and patient points of view resulted in the nurse experiencing a vulnerability in responding to the patient which helped recognition of a readiness in both nurse and patient to move forward in partnership. Gastmans illuminates this interaction of nurse and patient by noting that attentive nurses ". . . are challenged to step out of their own personal framework in order to take up that of the patient, so that they can better understand his or her real-life situation" (p. 147).

This responsive directing of one's self, in partnership with the patient or family, to chart a patient-centered healing path is similar to Jacob's (2013) adaptation of Carper's (1978) pattern of personal knowing to a pattern of advocacy, reflecting Gadow's (1980) existential advocacy. Jacob asserts this advocacy knowledge is tied to the innovation pattern of research and offers potentially innovative, value added practices to the realm of nursing in care of the individual and in the broader institutional environment. The conceptual values of advocacy, vulnerability, and a readiness factor helped nurse and/or patient in this study negotiate realistic goals that were part of the healing path toward facilitating the patient's best potential.

Realizing the Patient's Best Potential.

Realizing the patient's best potential did not always occur. However, nurses were quick to observe outcomes which seemed to reflect a change in the quality of life for the patient and/or family. This change shares features of human flourishing, named by

Jacobs (2013) as the end or telos of nursing. In essence, nurses first envision the best potential with or without the patient, depending on his or her acuity of illness. When the patient is ready, nurses partner with the patient's desire to work toward that potential. How the nurse applied his or her knowledge often had a direct influence in the outcome observed. This seasoned nurse (FF) described interaction with two patients of different faiths facing the end of life: one with brain cancer who was a Buddhist, the other with heart and kidney failure who was a Sikh. Both were on a medical surgical floor. Her nursing practice of often sensing "this is the one with whom I should share today" kept her alert on a very busy day for taking time to hear from the patient. When the first patient initiated conversation ("I just really want to know the truth" and within minutes communicated his fear of dying and concern of "who will take care of my family?"), the nurse learned his Buddhist faith was not providing comfort. So, in contrasting the Buddhist and Christian response to suffering, this nurse offered the patient who was open and seeking knowledge of Jesus and his provision of salvation care. This patient and his wife welcomed this care and the Savior who provided it. In contrast, the Sikh patient was not interested in hearing about the Christian way, and so the nurse focused on his belief system and supported the family's presence with him. This care parallels Rasmussen and Evardsson's (2007) atmosphere of hospitality, safety, and "everydayness" that contributes to the concept of "at-homeness" for the palliative care patient and, also, Gastmans's (2013) dignity-enhancing care.

When the nurse models his or her own commitment to spiritual values and practices, each goes the extra mile to assess and honor the spiritual values and practices of patients, whether of similar or of different belief systems. This practice shares

elements with Barss's (2012) T.R.U.S.T. model of inclusive spiritual care depicting culturally safe spiritual care. Consistently modeling the inclusion of the emotional and spiritual needs of the patient requires spiritual self-awareness and sensitivity of the nurse, personal stamina, and conviction that care, versus other nurse agendas, is the real patient need (Arman & Rehnsfeldt, 2007; Peacock & Nolan, 2000; van Leeuwen, Tiesinga, Jochemasen, & Post, 2007).

Referring to two studies mentioned earlier (Broyles et al., 2008; Lincoln & Johnson, 2009) that used versions of Watson's (2008) Philosophy and Science of Caring, both emphasize the direct role of humanistic and/or monistic (Pesut, 2008), person-to-person approach as the primary source of care. Similarly, these Christian nurses spoke of knowing the patient as a unique individual and the nurse's perspective as a bridge to partnership in creating a healing environment. In contrast, they readily accessed and spoke of spiritual strategies which reflected a theistic-based approach in creating a wholistic, healing environment.

Earlier reference was also made to Levin's (2011) three prominent antecedent healer attributes of focus, compassion, and intention stating this study will primarily address the focus attribute. Conceptual categories of "knowing as unique individual" and "nurse perspective" being a bridge to partnership are the findings which illustrate the focus of the nurse on healing. *Charting the healing path* as the GT core category addresses the attribute of focus and intention in combination. Compassion and being intentional were the two attributes characteristic of these Christian nurses.

Best Potential System-wide

Hospital and unit-wide programs and supports were reported to enhance the

relational, space, and time strategies of the nurses. Administrative buy-in and participation in execution of these efforts were experienced by nurses as positive initiatives and reinforcements. The exceptions voiced were related to programs or initiatives which drew nurses away from the bedside. This view of the organizational commitment to creating a healing environment shares aspects of the Optimal Healing Environment movement and its commitments including support for holistic patient-centered nursing care at the bedside, use of physical space to improve the health care experience, and incorporation of spirituality into the health care provision (Findlay et al., 2006). It is also similar to the conceptual structure of person-centered nursing constructs of prerequisites, the care environment, person-centered processes, and outcomes (McCance et al., 2011; McCormack et al., 2010). According to McCormack and McCance (2006), the care environment is where supportive organizational efforts create a synergy for system-wide change in how service is delivered and, consequently, experienced.

Implications for Practice, Theory, and Research

Grounded theory from the perspective of these Christian nurses offers a means of understanding how “charting a healing path” summarizes the strategies they used to create a healing environment and enhance well-being in their patients. General implications for nursing advocacy in creating a healing environment are given in three categories: implications for nursing practice, nursing theory, and nursing research.

Implications for Practice

Implications for practice from this study include prioritizing knowing, knowing as a bridge to, and partnerships for healing. Knowing and the nurse’s knowledge—

empirical, aesthetic, spiritual, ethical, and personal ways of knowing—are ready resources to engage patients in moving toward their best potential (Benner, Sutpehn, Leonard, & Day, 2010; Benner et al., 2009; Jacobs, 2013; Swanson, 1993). Hospital and academic educators can encourage development of these different knowledge realms with programs and supports focused for both individual and group efforts, e.g. journaling clubs; nurse zoning groups, where nurses from a section of the institution hold “best healing practice events” and brainstorm how these could be applied in other contexts and patient/staff situations; and healing skills check-off days where the emphasis is shown to encompass relational and technical knowing skills, simultaneously. Extending these skills in service of knowing others and developing partnerships for healing also requires institutional backing and support (Halldorsdottir, 2008).

Bridge-building and partnerships for healing are two other foci that offer nursing practice a wealth of development opportunities. Seminars which focus on conceptual and actual communication and idea bridge-building practice would stimulate the knowledge base and help the nurse apply it at both the individual patient level and the work environment level. Bridge-building for a culture of care at the unit, section, or hospital-wide level would engage nurses in designing what would be a healing work environment for them, and it would also challenge them to meld that with knowing and partnering with the patient for healing. In chapter four, the statement was made that changing the landscape of “the possible” allows the best potential to surface. Expanding nurses’ view of “the possible” can encourage new partnerships for healing to form, create a new valuing of “traditional nursing body therapies” (Benner & Wrubel, 1989, p. 79), and foster some basic sources of nurse and patient satisfaction. Bridge-building involves

envisioning a way to connect separate entities; the possibilities seem unlimited within nursing for “charting a healing path.”

Practice settings need to integrate the mission of the facility with the nursing professional practice model, or theory-based model, to identify the personal, discipline, and institutional contributions toward creating a healing environment. In “charting the healing path,” where the institution holds whole patient care as a value, McSherry’s (2006) principal components model for advancing spirituality and spiritual care (think whole person care) may be a helpful tool to frame nursing practice. This model applies the components in two axes: (1) the innate nature of spirituality and (2) organizational context of providing and supporting spiritual care. McSherry suggests the more priority the institution attaches to the spiritual dimension of care, “the more it should correlate with improvements in service provision in this area which will ultimately influence the quality of spiritual care in terms of strategy, structure, and process” (p. 914). Thus, investment in whole person care will invest in wholeness of staff and teach and model a focus on wholeness of patients, staff, and the system of health care delivery. Another available model would be the Donabedian model of structure, process, and outcome variables, used by the Tzu Chi Institute, utilizing optimal healing environment criteria (Findlay & Verhoef, 2004).

Aligning one’s self with other like-minded professionals and developing and sharing creative space, time, and relationship foci for a healing environment require both individual and institutional focused efforts. Often, finding people of influence within the institution and working with them to develop what is desired, but currently lacking, requires going above and beyond the job role. For some, this is part of a calling and

passion to make a lasting difference. Others wait until those with such passion have answered their call, created a venue, and provided opportunity to give wholeness and healing environment behaviors a try.

Implications for Theory

Implications from this study for theory prioritize the patient-nurse interaction domain, the nurse's input in that interaction, and its consequent outcomes. See Meleis's (2007, p. 467) concepts central to the domain of nursing. An innovation pattern of research (Jacobs, 2013) could address new ways of access to partnerships and how nurses can facilitate them. Examples could build on Ingadottir and Honsdottir's (2010) partnership-based nursing practice for cohorts of illness-related clients and families. The implementation of the Affordable Care Act opens the door for theory- and practice-based research combinations with nurses empowering clients to share self-care knowledge and management strategies as consequent outcomes. Research employing specific theories can investigate how the nursing environment is pivotal in facilitating these desired outcomes.

Meleis (2010) gives one example of theory-based research with effects of environment on transitional care and optimal outcomes (Brooten & Naylor, 2010). Outcomes include sociocultural and economic factors and could include policy development factors. This resource can provide a model for others in looking at various situation specific environments. One such example would be the outcomes of nurse-teen partnership in school-based health clinics (environment) with sexually active teens. Possible outcomes include prevention of sexually transmitted infections and teen pregnancy and giving permission to not be sexually active. Another example would be

the outcomes of interdisciplinary team partnerships in transitional living facilities for run-away teens. Possible outcomes include completion of school and/or job-training programs (high school diploma, G.E.D., or community college vocational training programs) and maintaining healthy reproductive and sexuality practices.

Theory which explicates the role of the environment by giving description of “. . . properties, components, and dimensions of environment that are healthy or that help in maintaining or changing health care outcomes” (Meleis, 2007, p. 477) is both a research and theory recommendation, and it is a next step in further development of the environment as a meta-paradigm concept. In this study, both relational and spatial aspects of the healing environment are seen. Nurse-patient partnership is a relational and spatial property of a healing environment. Setting realistic goals towards and facilitating best potentials could be seen as sub-categories of a property. But this researcher concludes the process of setting goals and nurse therapeutics to help achieve those goals are empiric dimensions that help in maintaining or changing health care outcomes. Two potential modifiers of either the nurse-patient partnership or these empiric dimensions are (1) self-identified Christian nurses and (2) practicing in faith-based hospitals.

Fawcett and Desanto-Madeya (2013) describe categories of knowledge which foster a different body of knowledge about the metaparadigm concepts. Features of at least two categories of knowledge are present in the findings of this study. First, the developmental category of knowledge asserts change is directional, and change potentials are inherent in the human. This change potential is one way of describing the best potential toward which the nurse-patient partnership moves, embracing both the internal and external elements of the environment. A second category of knowledge is the

interaction category derived from symbolic interactionism. A person's perceptions of the people, the environment, and the situation depend on the meanings attached to the phenomena experienced, and behavior flows from those meanings. The goals set for healing derive from the perceptions, interpretations, and interaction with others in the healing environment, particularly from the nurse-patient partnership.

Thus, the "charting the healing path" model offers that partnership, and the bridge to partnership are properties around which theorists of nursing care can view the environment construct. The question can be asked, "How does partnership maintain or challenge healthcare outcomes?" Additionally, goal setting and facilitating best outcomes are dimensions of environment that can be further developed.

Implications for Research

Implications for future research include (1) expanding the sample to include other care-giver perspectives in strategies used to create a healing environment; (2) adding a measure of caring or spirituality scale (e.g., the Caring Assessment for the Direct Care Giver) instrument plus a spiritual well-being scale of nurses; (3) study of Christian nurses who are practicing in non-faith based hospitals and non-Christian nurses in those same hospitals to determine commonalities and differences; (4) implementing a nurse-patient paired study on strategies which create a healing environment; (5) focused study on the bridge metaphor and how internal and external aspects of relationship facilitate bridge-building for partnership or not; (6) partnering with other ongoing research to expand nursing intervention and readiness factors (e.g., design a study around one of the components of the Barss (2012) T.R.U.S.T model) with intent to locate interventions which activate the healing response in patients related to (a) nurse understandings or (b)

patient seeking related to the current health/illness situation; or (7) attempt some focused research pilot with the Optimal Healing Environment (OHE) research group in one domain of environment for healing studied there, e.g., documentation and measurement of readiness factors in a unit or facility desirous of making patient-centered healing environment change) (Findlay & Verhoef, 2004).

Since health care in the U.S. is moving in the direction of community aggregates of patients grouped according to health challenges, specific nurse-led healing interventions could be tested within an aggregate. For example, one intervention would be the effect of deep breathing, meditation, and use of medication compared to medication alone, on a cohort of patients with a specific respiratory illness such as asthma patients with symptoms in the green, or yellow stages. Another intervention would be the use of self-selected music favorites, while walking, for increasing ambulation capacity of elders with compromised mobility.

Expanding on the health-promotion behaviors literature review of research efforts related to healing (O'Donnell, 2004), one or more social or spiritual interventions could be studied on similar aggregates. One example, from an explicitly Christian perspective, would be the God-promise/patient accountable action meditation program paired with exercise regimen for obese 20-30-year old working women measuring locus of control and motivation for health promotion changes over 3, 6, and 12 month periods. Defining positive interventional action for any at-risk group could reveal strategic initiatives for health and healing environment strategies for closely related patient or care-giver groups.

Summary

Knowing the patient, the juncture of nurse and patient points of view, and

partnering with the patient were substantive categories of “charting the healing path” which hold potential for developing the environment domain of nursing knowledge. This partnership seeks best potential of self-care knowledge and management to be realized incrementally during and after hospitalization. The “charting the healing path” model holds capacity to inform the system and power the mission of the institution forward in creating a healing environment and enhancing well-being for hospitalized patients.

Limitations

Reflexivity

The use of GGT methodology necessarily means the researcher perspective is influential in data collection and analysis. The subjective research interaction between the researcher, her background, and data analysis is situated in the context of active reflection within the constant comparative method. Thus, reflexivity openly acknowledges researcher background and self-awareness as a possible source of bias, and as a source of insight, within careful analysis. This researcher is a Christian nurse whose commitment to Christ and a Christian view of life involved a radical life transformation in the year prior to beginning nursing school. Thus, healing and spiritual care have been enduring foci of interest for over 40 years.

Nurse Perspective

Though the nurses in this study were recommended by nurse managers or leaders within the institution for participation, they self-selected once contacted regarding participation in the study. This self-reflection means those who chose to participate may not be representative of the general population of Christian nurses in these institutions with expertise in creating a healing environment. At the same time, they were the ones

showing enough interest in the topic to be interviewed and contribute their expertise to the study.

Interviewing nurses only gives a limited perspective on creation of a healing environment. This is the first study of its kind, so it generates a perspective which can be used for comparison with a paired nurse-patient study in the future. Doing focus group interviews versus individual interviews could produce additional perspectives. However, individual interviews may result in freedom for some nurses to voice their perspectives and deeply held commitments versus having to speak over or in contrast to others.

Sample Size

According to classic grounded theory methodology, sample size sufficient to generate data saturation for constant comparison was obtained with $n = 15$. This was a largely homogenous group of 11 white, 2 Hispanic, and 2 Filipino nurses with a breadth of age and years of practice. Sample participants included three male, 12 female, two night shift, and 13 day shift nurses from two southern California hospitals; one is a 400+ bed community hospital, the other a tertiary regional medical center. A purposive sample limitation is that it is not representative of the nurse population at large. However, within grounded theory this limitation becomes a strength by which a clear picture is seen of how this particular group solved the problem they faced: helping patients get better. This fact limits the transferability of findings to nurses who are self-proclaimed Christians practicing in faith-based hospitals. However, these nurses gave a robust sampling of 62 patient examples of creating a healing environment.

Focus On a Healing Environment

The questions asked in this study may have limited the discussion in a way the

researcher did not intend. In the two practice interviews, both with masters degree prepared nurses, the nurses spoke of time, space and relationship factors. The researcher noticed, in the first two study interviews, that nurses mentioned institutional and unit programs and supports, as well as peer supports, only within patient exemplars. At that point, a question was added to ask about institution-wide, unit-based or peer supports that contributed to their creation of a healing environment. Answers given to this question were most frequently the mention of interdisciplinary support professionals. By research design, it was not possible to interview these other team members for their perspectives, but future studies could interview interdisciplinary team members and use focus groups to facilitate expansion of ideas and topics relevant to strategies beyond the nurse-patient relationship.

One serendipitous finding of this study was hearing a majority of nurses interviewed name spiritual strategies as part of how they create a healing environment. Given these were Christian nurses, it is not surprising that 40% ($n=25$) of the 62 exemplars given described breadth and depth of spiritual assessment and intervention. As stated earlier, the researcher was careful not to ask for exemplars of a spiritual nature unless by the very end the nurse had not mentioned it. This situation happened with one nurse only.

Conclusion

Commitment to creating an optimal healing environment will involve nurses in every dimension of this creative endeavor--at the bedside, within the unit culture, and across organizational structures. The implications of charting a healing path for realizing best outcomes declare nurses have relational knowledge, skill and expertise in knowing

and partnering with the patient in the quest for healing and recovery of well-being. For these Christian nurses, this nurse knowledge and resource was infused with spiritual truths incorporated in their character yet ready to use when specific intervention was appropriate. These truths, rarely the focus of care, were most frequently accessed in partnering with the patient to envision and facilitate best potential outcomes. Thus, the categories of nurse knowing and partnering led to the outcomes of self-care knowledge and self-care management where best potentials were realized in concert with the nurse while still in the hospital. The next phase of health and well-being awaits the patient and family as they proceed home.

REFERENCES

- Alligood, M. R., & Tomey, A. M. (2010). *Nursing theorists and their work* (7th ed.). Maryland Heights, MO: Mosby Elsevier.
- Altimier, L. B. (2004). Healing environments: For patients and providers. *Newborn and Infant Nursing Reviews*, 4(2), 89-92. doi: 10.1053.j.nanier.2004.03.001
- Alvsvag, H. (2010). Philosophy of caring. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing theorists and their work* (7th ed., pp. 165-189). Maryland Heights, MO: Mosby Elsevier.
- Anderberg, P., Lepp, M., Berglund, A., & Segesten, K. (2007). Preserving dignity in caring for older adults: A concept analysis. *Journal of Advanced Nursing*, 59(6), 635-643.
- Andrews, H. A., & Roy, C. (1986). *Essential of the Roy Adaptation Model*. Norwalk, CN: Appleton-Century-Crofts.
- Arman, M., & Rehnsfeldt, A. (2007). The 'little extra' that alleviates suffering. *Nursing Ethics*, 14(3), 372-384.
- Artinian, B. A. (1991). The development of the Intersystem Model. *Journal of Advanced Nursing*, 16, 194-205.
- Artinian, B. M., Giske, T., & Cone, P. H. (Eds.). (2009). *Glaserian grounded theory in nursing reserach: Trusting emergence*. New York, N. Y. : Springer.
- Barss, K. S. (2012). T.R.U.S.T.: An affirming model for inclusive spiritual care. *Journal of Holistic Nursing*, 30(25), 24-34. doi: 10.1177/0898010111418118
- Benner, P. (1994). *Interpretive phenomenology: Embodiment, caring and ethics in health and illness*. Thousand Oaks, Ca.: Sage.
- Benner, P., Sutpehn, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. Stanford, Ca.: The Carnegie Foundation for the Advancement of Teaching.
- Benner, P., Tanner, C., & Chesla, C. (2009). *Expertise in nursing practice: Caring, clinical judgment, and ethics* (2nd ed.). New York; NY: Springer Publishing.
- Benner, P., & Wrubel, J. (1989). *The primacy of care: Stress and coping in health and illness*. Menlo Park Ca.: Addison-Wesley.
- Benzein, E. G., Hagberg, M., & Saveman, B. I. (2008). 'Being appropriately unusual': A challenge for nurses in health-promoting conversations with families. *Nursing Inquiry*, 15(2), 106-115. doi: 10.1111/j.1440-1800.2008.00401.x

- Berbiglia, V. A., & Banfield, B. (2010). Self-care deficit theory of nursing. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing theorists and their work* (7th ed., pp. 265-285). Maryland Heights, MO: Mosby Elsevier.
- Bishop, L. P., & Griffin, C. (2006). Holistic healing methods positively advance patient care. *Nursing Management*, 37(7), 30-35.
- Block, K. I., Block, P., & Gyllrhaal, C. (2004). The role of optimal healing environments in patients undergoing cancer treatment: Clinical research protocol guidelines. *Journal of Alternative & Complementary Medicine*, 10(Supplement), S-157-S-170.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Berkeley, Ca.: University of California.
- Bolles, S., & Maley, M. (2004). Designing relational models of collaborative integrative medicine that support healing processes. *The Journal of Alternative and Complementary Medicine*, 10(Supplement 1), S-61 - S-69.
- Boykin, A., Schoenhofer, L. O., Baldwin, J., & McCarthy, D. (2005). Living caring in practice: The transformative power of the theory of nursing as caring. . *International Journal for Human Caring*, 9(3), 15-19.
- Brady, D. S. (2011). Using quality and safety education for nurses (QSEN) as a pedagogical structure for course redesign and content. *International Journal of Nursing Education Scholarship*, 8(1). Retrieved from <http://0-www.bepress.com.catalogue.llu.edu/>
- Brooten, D., & Naylor, M. D. (2010). Transitional environments. In A. I. Meleis (Ed.), *Transitions theory: Middle-range and situation-specific theories in nursing research and practice* (pp. 465-480). New York, NY: Springer.
- Broyles, G., Washington, G. T., Lowry, L. W., Gugliotta, B., Eorgan, P., & Wilhoit, K. (2008). Innovative solutions: Registered nurses' perceptions of the work environment before and after adult intensive care unit renovations. *Dimensions of Critical Care Nursing*, 27(4), 180-188. doi: 10.1097/01.DCC.0000286855.76902.ee
- Brunner, N. (2009). The power of touch in a high-tech world, it pays to reach out. *Massage & Bodywork, Autumn-Winter*, 26-29.
- Carper, B. (1978). Fundamental patterns of knowing. *Advances in Nursing Science*, 1(1), 13-23.
- Carpman, J. R., & Grant, M. A. (1993). *Design that cares*. San Francisco, Ca.: Jossey-Bass.

- Carson, V. (2011). What is the essence of spiritual care. *Journal of Christian Nursing*, 28(3), 173.
- Charmel, P. M., Frampton, S., & Gilpin, L. (Eds.). (2003). *Putting patients first - Designing and practicing patient-centered care*. San Francisco, Ca.: Jossey-Bass.
- Clarke, S. P., & Aiken, L. H. (2008). An international hospital outcomes research agenda focused on nursing: Lessons from a decade of collaboration. *Journal of Clinical Nursing*, 17(24), 3317-3323. doi: 10.1111/j.1365-2702.2008.02638.x
- Cody, W. K. (1996). Response to: "On the requirement for a metaparadigm: An invitation to dialogue.". *Nursing Science Quarterly*, 9, 97-99.
- Coffman, S. (2010). Theory of bureaucratic caring. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing theorists and their work* (7th ed.). Maryland Heights, MO: Mosby Elsevier.
- Cone, P. M. H. (2006). *Reconnecting: A grounded theory study of formerly homeless mothers*. Doctor of Philosophy, University of California, San Francisco. Available from ProQuest Dissertations & Theses (3221155)
- Coughlin, M., Gibbins, S., & Hoath, S. (2009). Core measures for developmentally supportive care in neonatal intensive care units: Theory, precedence and practice. *Journal of Advanced Nursing*, 65(10), 2239-2248. doi: 10.1111/j.1365-2648.2009.05052.x
- Dijkstra, K., Peitense, M., & Pruyn, A. (2006). Physical environmental stimuli that turn healthcare facilities into healing environments through psychologically mediated effects: Systematic review. *Journal of Advanced Nursing*, 56(2), 166-181. doi: 10.1111/j.1365-2648.2006.03990.x
- Dossey, B. (2010). Holistic nursing: From Florence Nightingale's historical legacy to 21st century global nursing. *Holistic Nursing* 16(5), 14-16.
- Dossey, L. (2010). Coherence, chaos and the coincidentia oppositorum. *Explore: The Journal of Science and Healing*, 6(6), 339-345.
- Dowd, T. (2010). Theory of comfort. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing theorists and their work* (7th ed., pp. 706-721). Maryland Heights, MO: Mosby Elsevier.
- Dube, J. A. O., Barth, M. M., Cmiel, C. A., Cutshall, S. M., Olson, S. M., Sulla, S. J., . . . Holland, D. E. (2008). Environmental noise sources and interventions to minimize them: A tale of 2 hospitals. *Journal of Nursing Care Quality*, 23(3), 216-224; quiz 225-216. doi: 10.1097/01.ncq.0000324585.68966.51
- Durston, P. (2006). Partners in caring: A partnership for healing. *Nursing Administration Quarterly*, 30(2), 105-111.

- Edvardsson, J. D., Sandman, P., & Rasmussen, R. H. (2003). Meanings of giving touch in the care of older patients: Becoming a valuable person and professional. *Journal of Clinical Nursing*, 12(4), 601-609. doi: 10.1046/j.1365-2702.2003.00754.x
- Elwell, W. A., & Comfort, P. W. (Eds.). (2001). *Tyndale Bible dictionary. Tyndale reference library (306)*. Wheaton, IL: Tyndale House Publishers.
- Enhancing the Healing Environment. (2012) Retrieved Nov 24, 2012, from <http://www.kingsfund.org.uk/projects/enhancing-healing-environment>
- Erickson, H. L. (2007). Philosophy and theory of holism. *Nursing Clinics of North America*, 42(2), 139-163. doi: 10.1016/j.cnur.2007.03.001
- Faull, K., Hills, M. D., Cochrane, G., Gray, J., Hunt, M., McKenzie, C., & Winter, L. (2004). Investigation of health perspectives of those with physical disabilities: The role of spirituality as a determinant of health. *Disability & Rehabilitation*, 26(3), 129-144.
- Fawcett, J. (1984). The metaparadigm of nursing: Present status and future refinements. *Image: The Journal of Nursing Scholarship*, 16(3), 84-87.
- Fawcett, J., & Desnato-Madeya, S. (2013). *Contemporary nursing knowledge: Analysis and evaluation of nursing models and theories* (3rd ed.). Philadelphia, PA: F. A. Davis Company.
- Findlay, B., Smith, K., Finch, M., & Loveless, S. (2006). Survey of healing environments in hospitals: Nature and prevalence. Retrieved from Samulei Institute: Exploring the science of healing website: <http://www.siib.org/our-research/optimal-healing-environments>
- Findlay, B., & Verhoef, M. (2004). Operationalizing the concept of the optimal healing environment in clinical settings: The importance of "readiness". *Journal of Alternative and Complementary Medicine*, 10(S1), S-121-S-126.
- Foote, F. O., & Schwartz, L. (2012). Holism at the National Intrepid Center of Excellence (NICoE). *Explore: The Journal of Science and Healing*, 8(5), 282-290.
- Fowler, M., & Peterson, B. S. (1997). Spiritual themes in clinical pastoral education. *Journal of Supervision and Training in Ministry*, 18, 46-54.
- Freese, B. T., & Lawson, T. G. (2010). System model. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing theorists and their work* (7th ed., pp. 309-334). Maryland Heights, MO: Mosby Elsevier.
- Gadow, S. (1980). Existential advocacy: Philosophical foundations of nursing. In S. F. Spicker & S. Gadow (Eds.), *Nursing: Images and ideals; Opening dialogue with the humanities* (pp. 79-101). New York: NY: Springer Publishing.

- Gallagher, A. (2004). Dignity and respect for dignity -- two key health professional values: Implications for nursing practice. *Nursing Ethics*, 11(6), 587-599.
- Gardner, G., Collins, C., Osborne, S., Henderson, A., & Eastwood, M. (2009). Creating a therapeutic environment: A non-randomised controlled trial of a quiet time intervention for patients in acute care. *International Journal of Nursing Studies*, 46, 778-786. doi: 10.1016/j.ijnurstu.2008.12.009
- Gasquoine, S. (2001). 'Basic nursing care' is essential nursing care... Kathy Lowe's letter in the March issue of Kai Tiaki Nursing New Zealand. *Kai Tiaki Nursing New Zealand*, 7(5), 4-4.
- Gastmans, C. (2013). Dignity-enhancing care: A foundational ethical framework. *Nursing Ethics*, 20(2), 142-149. doi: 10.1177.0969733012473772
- Gauthier, D. M. (2002). The meaning of healing near the end of life. *Journal of Hospice & Palliative Nursing*, 4(4), 220-227.
- Geary, H. (2003). Facilitating an organizational culture of healing in an urban medical center. *Nursing Administration Quarterly*, 27(3), 231-239.
- Geffen, J. R. (2004). Creating optimal healing environments for patients with cancer and their families: Insights, challenges, and lessons learned from a decade of experience. *Journal of Alternative & Complementary Medicine*, 10(Supplemental), S-93-S-102.
- Geimer-Flanders, J. (2009). Creating a healing environment: Rationale and research overview. *Cleveland Clinic Journal of Medicine*, 76 Suppl 2, S66-69. doi: 10.3949/ccjm.76.s2.13
- Geller, G., & Warren, L. R. (2004). Toward an optimal healing environment in pediatric rehabilitation. *Journal of Alternative & Complementary Medicine*, 10(Supplement), S-179-S-190.
- Giske, T., & Artinian, B. M. (2009). Learning Glaserian grounded theory by doing it. In B. M. Artinian, T. Giske & P. H. Cone (Eds.), *Glaserian grounded theory in nursing research: Trusting emergence* (pp. 49-72). New York, NY: Springer.
- Glaser, B. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, Ca.: Sociology Press.
- Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, Ca. : Sociology Press.
- Glaser, B. G. (2001). *The grounded theory perspective: Conceptualization contrasted with description*. Mill Valley, CA: Sociology Press.

- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory*. Hawthorne, NY: Aldine Publishing Company.
- Goddard, N. (1995). 'Spirituality as integrative energy': A philosophical analysis as requisite precursor to holistic nursing practice. *Journal of Advanced Nursing*, 22, 808-815.
- Goddard, N. C. (2000). A response to Dawson's critical analysis of 'spirituality as "integrative energy."'. *Journal of Advanced Nursing*, 31(4), 368-379.
- Guenther, R., & Hall, A. G. (2007). Healthy buildings: Impact on nurses and nursing practice. *Online Journal of Issues in Nursing*, 12(2), 3-3.
- Halldorsdottir, S. (2008). The dynamics of the nurse-patient relationship: Introduction of a synthesized theory from the patient's perspective. *Scandinavian Journal of Caring Sciences*, 22, 643-652. doi: 10.1111/j.1471-6712.2007.00569.x
- Holt, C. L., Lee, C., & Wright, K. (2008). A spiritually based approach to breast cancer awareness: Cognitive response analysis of communication effectiveness. *Health Communication*, 23(1), 13-22.
- Horowitz, S. (2008). Optimal healing environments: A prescription for health. *Alternative and Complementary Therapies*, 14(6), 300-305. doi: 10.1089/act.2008.14607
- Horsburgh, R. (1995). Healing by design. *New England Journal of Medicine*, 333, 735-740. doi: DOI: 10.1056/NEJM199509143331117
- Howerter, A., Hollenstein, T., Boon, H., Niemeyer, K., & Brule, D. (2012). State-Space grid analysis: Applications for clinical whole systems complementary and alternative medicine research. *Forsch Komplementmed*, 19 (suppl 1), 30-35. Retrieved from doi:10.1159/000335187
- Hui, E. C. (1997a). Healing. In R. Banks & R. P. Steeves (Eds.), *The complete book of everyday Christianity*. Downers Grove, IL: InterVarsity Press.
- Hui, E. C. (1997b). Health. In R. Banks & R. P. Steves (Eds.), *The complete book of everyday Christianity* (pp. 481-484). Downers Grove, IL: InterVarsity Press.
- Hunt, L. (2011). Environments designed to heal. *Nursing Older People*, 23(1), 14-17.
- Ingadottir, T. S., & Jonsdottir, H. (2010). Partnership-based nursing practice for people with chronic obstructive pulmonary disease and their families: Influences on health-related quality of life and hospital admissions. *Journal of Clinical Nursing*, 19(19/20), 2795-2805. doi: 10.1111/j.1365-2702.2010.03303.x
- Jacobs, B. B. (2013). An innovative professional practice model: Adaptation of Carper's patterns of knowing, patterns of research, and Aristotle's intellectual virtues. *Advances in Nursing Science*, 36(4), 271-288.

- Jarrin, O. (2012). The integrality of situated caring in nursing and the environment. *Advances in Nursing Science*, 35(1), 13-24. doi: 10.1097/ANS.0b013e3182433b89
- Jesse, D. E. (2010). Watson's philosophy and theory of transpersonal caring. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing Theorist and Their Work* (7th ed., pp. 91-112). Maryland Heights, MO: Mosby Elsevier.
- Jonas, W. B., Chez, R. A., Duffy, B., & Strand, D. (2003). Investigating the impact of optimal healing environments. *Alternative therapies in health and medicine*, 9(6), 36.
- Kerfoot, K., & Neumann, T. (1992). Creating a healing environment: The nurse manager's challenge. *Nursing Economics*, 10(6), 423-425.
- King, I. E. (1981). *A theory for nursing: Systems, concepts, process*. New York, NY: J. Wiley.
- Kligler, B., Homel, P., Harrison, L. B., Levenson, H. D., Kenney, J. B., & Merrell, W. (2011). Cost savings in inpatient oncology through an integrative medicine approach. *American Journal of Managed Care*, 17(12), 779-784.
- Kolcaba, K. (2006). Comfort theory: A unifying framework to enhance the practice environment. *Journal of Nursing Administration*, 36(11), 538-554.
- Kotzer, A. M., Zacharakis, S. K., Reynolds, M., & Beuning, R. (2011). Evaluation of the built environment: Staff and family satisfaction pre- and post-occupancy of The Children's Hospital. *Health Environments Research & Design Journal (HERD)*, 4(4), 60-78.
- Leininger, M. (1994). Quality of life from a transcultural nursing perspective. *Nursing Administration Quarterly*, 7, 22-28. doi: 10.1177/089431849400700109
- Leininger, M. (1996). Culture care theory, research, and practice. *Nursing Science Quarterly*, 9, 71-78. doi: 10.1177/089431849600900208
- Levin, J. (2011). Energy healers: Who they are and what they do. *Explore: The Journal of Science and Healing*, 7(1), 13-26. doi: 10.1016/j.explore.2010.10.005
- Levine, M. E. (1971). *Renewal for nursing*. Philadelphia, PA: F. A. Davis.
- Lincoln, V., & Johnson, M. (2009). Staff nurse perceptions of a healing environment. *Holist Nurs Pract*, 23(3), 183-190. doi: 10.1097/HNP.0b013e3181a056fd
- LLUSN. (2012). *Nursing Science Seminar N664*. School of Nursing. Loma Linda University. Loma Linda, Ca.

- Lomborg, K., & Kirkevold, M. (2005). Curtailing: Handling the complexity of body care in people hospitalized with severe COPD. *Scandinavian Journal of Caring Sciences*, *19*, 148-156.
- Lomborg, K., & Kirkevold, M. (2006). Achieving therapeutic clarity in assisted personal body care: Professional challenges in interactions with severely ill COPD patients. *Journal of Clinical Nursing*, *17*(16), 2155-2163. doi: 10.1111/j.1365-2702.2006.01710.x
- Madrid, M. M., Barrett, E. A., & Winstead-Fry, P. (2010). A study of the feasibility of introducing therapeutic touch into the operative environment with patients undergoing cerebral angiography. *Journal of Holistic Nursing*, *28*(3), 168-174. doi: 10.1177/0898010110369173
- McCance, T., McCormack, B., & Dewing, J. (2011). An exploration of person-centredness in practice. *Online Journal of Issues in Nursing*, *16*(2), 1-1. doi: 10.3912/OJIN.Vol16No02Man01
- McCormack, B., Karlsson, B., Dewing, J., & Lerdal, A. (2010). Exploring person-centredness: A qualitative meta-synthesis of four studies. *Scandinavian Journal of Caring Sciences*, *24*, 620-634. doi: 10.1111/j.1471-6712.2010.00814.x
- McCormack, B., & McCance, T. V. (2006). Development of a framework for person-centred nursing. *Journal of Advanced Nursing*, *56*(5), 472-479. doi: 10.1111/j.1365-2648/2006.04042.x
- McCraty, R. (2003). *The energetic heart: Bioelectromagnetic interactions between and within people*. (Publication No.02-035.). HeartMath Research Center, Institute of HeartMath., Boulder Creek, CA.
- McSherry, W. (2006). The principal components model: A model for advancing spirituality and spiritual care within nursing and health care practice. *Journal of Clinical Nursing*, *15*, 905-917. doi: 10.1111/j.1365-2702.2006.01648.x
- Meleis, A. I. (1975). Role insufficiency and role supplementation: A conceptual framework. *Nursing Research*, *24*, 264-271.
- Meleis, A. I. (2007). *Theoretical nursing: Progress and development* (4th ed.). Philadelphia, PA: Lippincott, Williams & Wilkins.
- Meleis, A. I. (Ed.). (2010). *Transitions theory: Middle-range and situation-specific theories in nursing research and practice*. New York, NY: Springer Publishing Company, LLC.
- Meleis, A. I., & Trangenstein, P. A. (2010). Facilitating transitions: Redefinition of the nursing mission. In A. I. Meleis (Ed.), *Transitions theory: Middle-range and situation-specific theories in nursing research* (pp. 65-72). New York, NY: Springer.

- Merleau-Ponty, M. (1962). *Phenomenology of perception* (C. Smith, Trans.). New York, NY: Routledge & Kegan Paul.
- Merleau-Ponty, M. (1963). *The structure of behavior* (A. Fischer, Trans. 9th ed.). Pittsburg, Pa.: Duquesne University Press.
- Mitchell, G. J., & Bournes, D. A. (2010). Humanbecoming. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing theorists and their work* (pp. 503-535). Maryland Heights, Mo.: Mosby Elsevier.
- Moreland, J. P., & Craig, W. L. (2003). *Philosophical foundations for a Christian worldview*. Downers Grove, IL: InterVarsity Press.
- Morse, J. M. (1996). Nursing scholarship: Sense and sensibility. *Nursing Inquiry*, 3, 74-82.
- Mount, B. (2003). Healing and palliative care: Charting our way forward. *Palliative Medicine*, 17(8), 657-658.
- National Research Council. (2011). *The future of nursing: Leading change, advancing health*. Washington, D.C.: The National Academies Press Retrieved from www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx.
- Nightingale, F. (1992). *Notes on nursing: What it is, and what it is not* (Commemorative ed.). Philadelphia, PA: J.B. Lippincott.
- O'Brien, M. E. (2011). *Spirituality in nursing: Standing on holy ground* (4th ed.). Sudbury, MA: Jones & Bartlett.
- O'Brien, M. E. (2014). *Spirituality in nursing: Standing on holy ground* (5th ed.). Washington, DC: The Catholic University of America.
- O'Donnell, M. (2004). Health-promotion behaviors that promote self-healing. *Journal of Alternative and Complementary Medicine*, 10(Supplement 1), S-49 - S-60.
- Orlando, I. J. (1961). *The dynamic nurse-patient relationship: Function, process and principles*. New York City, NY: G. P. Putnam & Sons.
- Orlando, I. J. (1990). *The dynamic nurse-patient relationship: Function, process and principles* (Pub. No. 15-2341 ed.). New York, NY: National League for Nursing.
- Park, J. G. (2009). Color perception in pediatric patient room design: Healthy children vs. pediatric patients. *Health Environments Research & Design Journal (HERD)*, 2(3), 6-28.
- Parse, R. R. (1993). The theory—research—practice triad. *Nursing Science Quarterly*, 6(1), 12. doi: 10.1177/089431849300600106

- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, Ca.: Sage.
- Peacock, J. W., & Nolan, P. W. (2000). Care under threat in the modern world. *Journal of Advanced Nursing*, 32(5), 1066-1070.
- Persky, G., Nelson, J., Watson, J., & Bent, K. (2008). Creating a profile of a nurse effective in caring. *Nursing Administration Quarterly*, 32(1), 15-20. doi: 10.1097/01.naq.0000305943.46440.77
- Pesut, B. (2008). A conversation on diverse perspectives of spirituality in nursing literature. *Philosophy*, 9, 98-109.
- Pesut, B., & Johnson, J. (2008). Reinstating the 'Queen': Understanding philosophical inquiry in nursing. *Journal of Advanced Nursing*, 61(1), 115-121. doi: 10.1111/j.1365-2648.2007.04493.x
- Pfeiffer, J. (2011). *Heal, healing, healer*. Unpublished Academic Paper. Azusa Pacific University. Azusa, California.
- Pfeiffer, J. B. (2010). *Heart intelligence in health and spirituality*. Unpublished Academic Paper. Azusa Pacific University. Azusa, Ca.
- Pfeiffer, J. B., Gober, C., & Taylor, E. J. (in press). How Christian nurses converse with patients about spirituality. *Journal of Clinical Nursing*.
- Pfetscher, S. A. (2010). Florence Nightingale: Modern nursing. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing theorists and their work* (pp. 71-90). Maryland Heights, Mo.: Mosby Elsevier.
- Price, B. (2009). Supporting patients' dignity in the community. *Primary Health Care*, 19(3), 40.
- Puchalski, C. M., & McSkimming, S. (2006). Creating healing environments. *Health Progress*, 87(3), 30-35.
- Quan, X., Joseph, A., & Ensign, J. C. (2012). Impact of imaging room environment: Staff job stress and satisfaction, patient satisfaction, and willingness to recommend. *Health Environments Research & Design Journal (HERD)*, 5(2), 61-79.
- Raanaas, R. K., Patil, G. G., & Hartig, T. (2010). Effects of an indoor foliage plant intervention on patient well-being during a residential rehabilitation program. *HortScience*, 45(3), 387-392.
- Radwin, L. E. (1996). "Knowing the patient": A review of research on an emerging concept. *Journal of Advanced Nursing*, 23(6), 1142-1146. doi: 10.1046/j.1365-2648.1996.12910.x

- Rasmussen, B. H., & Edvardsson, D. (2007). The influence of environment in palliative care: Supporting or hindering experiences of 'at-homeness'. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 27(1), 119-131.
- Rogers, M. (1992). Nursing science and the space age. *Nursing Science Quarterly*, 5(27), 27-34. doi: 10.1177/089431849200500108
- Sahlberg, B., Mi, Y. H., & Norbäck, D. (2009). Indoor environment in dwellings, asthma, allergies, and sick building syndrome in the Swedish population: A longitudinal cohort study from 1989 to 1997. *International Archives of Occupational & Environmental Health*, 82(10), 1211-1218. doi: 10.1007/s00420-009-0444-3
- Sakraida, T. J. (2010). Health promotion model. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing theorists and their work* (7th ed., pp. 434-453). Maryland Heights, Mo: Mosby Elsevier.
- Sandelowski, M. (1993). Theory unmasked: The uses and guises of theory in qualitative research. *Research in Nursing & Health*, 16(3), 213-218.
- Sandelowski, M. (1998). Writing a good read: Strategies for re-presenting qualitative data. *Research in Nursing & Health*, 21(4), 375-382.
- Saroglou, V., Buxant, C., & Tilquin, J. (2008). Positive emotions as leading to religion and spirituality. *Journal of Positive Psychology*, 3(3), 165-173.
- Schaefer, K. M. (2010). The conservation model. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing theorists and their work* (7th ed., pp. 225-241). Maryland Heights, MO: Mosby Elsevier.
- Schweitzer, M., Gilpin, L., & Frampton, S. (2004). Healing spaces: Elements of environmental design that make an impact on health. *Journal of Alternative & Complementary Medicine*, 10, S-71-S-83.
- Selanders, L. C. (2010). The power of environmental adaptation: Florence Nightingale's original theory for nursing practice. *Journal of Holistic Nursing*, 28(1), 81-88. doi: 10.1177/0898010109360257
- Shelly, J. A., & Miller, A. B. (1999). *Called to care: A Christian theology of nursing*. Downers Grove, Il.: InterVarsity Press.
- Sherman-Bien, S. A., Malcarne, V. L., Roesch, S., Varni, J. W., & Katz, E. R. (2011). Quantifying the relationship among hospital design, satisfaction, and psychosocial functioning in a pediatric hematology-oncology inpatient unit. *Health Environments Research & Design Journal*, 4(4), 34-59.
- Sieloff, C. L., & Messmer, P. R. (2010). Conceptual system and middle range theory of goal attainment. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing theorists and their work* (7th ed., pp. 286-308). Maryland Heights, MO: Mosby Elsevier.

- Sire, J. W. (2009). *The universe next door* (5th ed.). Downers Grove, IL: InterVarsity Press.
- Soderback, I., Soderstrom, M., & Schalander, E. (2004). Horticultural therapy: The 'healing garden' and gardening in rehabilitation measures at Danderyd Hospital Rehabilitation Clinic, Sweden. *Pediatirc Rehabilitation*, 7(4), 245-260.
- Straus, D. C. (2009). Molds, mycotoxins, and sick building syndrome. *Toxicology & Industrial Health*, 25(9/10), 617-635.
- Suzuki, T. (2010). Consideration of grand design for the care environment in hospitals--smell, lighting and sound. *Japan Hospitals*, 29, 65-73.
- Swanson, K. M. (1991). Empirical development of a middle range theory of caring. *Nursing Research*, 40(3), 161-166.
- Swanson, K. M. (1993). Nursing as informed caring for the well-being of othes. *Image: The Journal of Nusing Scholarship*, 25(4), 352-357.
- Swanson, K. M., & Wonjar, D. M. (2004). Optimal healing environments in nursing. *The Journal of Alternative and Complementary Medicine*, 10(1), S 43 - S 48.
- Thornton, L. (2005). The model of whole-person caring: Creating and sustaining a healing environment. *Holistic Nursing Practice*, 19(3), 106-115.
- Tillich, P. (1960). The impact of pastoral psychology on theological thought. *Pastoral Psychology*, 11(1), 17-23.
- Timmins, F. (2011). Remembering the art of nursing in a technological age, Guest Editorial, *Nursing in Critical Care*, pp. 161-163. Retrieved from <http://0-search.ebscohost.com.patris.apu.edu/login.aspx?direct=true&db=aph&AN=61140107&site=ehost-live>
- Travelbee, J. (1966). *Interpersonal aspects of nursing*. Philadelphia, PA: F. A. Davis.
- Vaajoki, A., Pietila, A.-M., Kankkunen, P., & Vehvilainen-Julkunen, K. (2011). Effects of listening to music on pain intensity and pain distress after surgery: An intervention. *Journal of Clinical Nursing*, 21, 707-718. doi: 10.1111/j.1365-2702.2011.03829.x
- Van Dover, L., & Pfeiffer, J. B. (2007). Spiritual care in Christian parish nursing: Bringing God near. *Journal of Advanced Nursing*, 57(2), 1-9. doi: 10.1111/j.1365-2648.2006.04081.x
- Van Dover, L. J., & Pfeiffer, J. (2012). Patients of parish nurses experience renewed spiritual identity: a grounded theory study. *Journal of Advanced Nursing*, 68(8), 1824-1833. doi: 10.1111/j.1365-2648.2011.05876.x

- van Leeuwen, R., Tiesinga, L. J., Jochemasen, H., & Post, D. (2007). Aspects of spirituality concerning illness. *Scandinavian Journal of Caring*, 21, 482-489.
- Van Rompay, T. J. L., & Tanja-Dijkstra, K. (2010). Directions in healthcare research: Pointers from retailing and services marketing. *Health Environments Research & Design Journal (HERD)*, 3(3), 87-100.
- Walker, J. K. (1994). Nurse managers making a difference: Creating a healing place. *Seminars for Nurse Managers*, 2(4), 234-238.
- Waller, S. (2012). Redesigning wards to support people with dementia in hospital. *Nursing Older People*, 24(2), 16-21.
- Waller, S., & Masterson, A. (2010). Designs that enhance care, Editorial, *Nursing Older People*, pp. 3-3. Retrieved from <http://0-search.ebscohost.com.catalog.llu.edu/login.aspx?direct=true&db=aph&AN=53982889&site=ehost-live>
- Watson, J. (1999). *Postmodern nursing and beyond*. Edinburgh, Scotland: Churchill Livingstone.
- Watson, J. (2001). Jean Watson: Theory of human caring. In M. E. Parker (Ed.), *Nursing theories and nursing practice* (pp. 344-354). Philadelphia, PA: F.A. Davis.
- Watson, J. (2008). *Nursing: The philosophy and science of caring* (Revised ed.). Boulder, Co.: University Press of Colorado.
- Willard, D. (2002). *Renovation of the heart: Putting on the character of Christ*. Colorado Springs, Co.: NavPress.
- Williams, A. (2010). Spiritual therapeutic landscapes and healing: A case study of St. Anne de Beaupre, Quebec, Canada. *Social Science and Medicine*, 70(10), 1633-1640. doi: 10.1016/j.socscimed.2010.01.012
- Winslow, E. H., & Jacobson, A. F. (1997). Designing spaces that heal. *American Journal of Nursing*, 97(3), 62.
- Wonjar, D. M. (2010). Theory of caring. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing theorists and their work* (7th ed., pp. 741-752). Maryland Heights, MO: Mosby Elsevier.
- Wood, E. A. (2007). Reflections. The healing power of touch. *Massage Therapy Journal*, 46(1), 174-175.
- Woolley, J., Perkins, R., Laird, P., Palmer, J., Schitter, M. B., Tarter, K., . . . Woolsey, M. (2012). Relationship-based care: Implementing a caring, healing environment. *MEDSURG Nursing*, 21(3), 179-184.

Zoinierek, C. D. (2014). An integrative review of knowing the patient. *Journal of Nursing Scholarship*, 46(1), 3-10. doi: 10.1111/jnu.12049

APPENDIX A

**A *PRIORI* DEFINITIONS OF MAJOR CONSTRUCTS FOR
PROPOSAL DESIGN AND DEFENSE**

Major constructs of a healing environment in nursing include healing, healing environment, well-being, transition, dignity, *holistic* and *wholistic* care, spirituality and intention. Each of these overlapping concepts will be reviewed with definitions given to frame the study.

Healing is recovery and restoration involving the whole person, their beliefs and values, their sense of identity and their community of support, which frequently includes relation to an ultimate Being (Pfeiffer, 2011). This recovery implies a state of being which was, in its inception, whole and became marred and dysfunctional. Thus, healing is recovery and restoration of wholeness or well-being in the individual, and the individual in relation to his or her God, community, and environment.

Healing environments are those which support healthy transitions and are intentionally created (Altimier, 2004; Meleis & Trangenstein, 2010). Healing environments require commitment of the caregiver and the system or organization of care if the environment is to promote recovery and restoration of well-being for patients and staff.

Well-being is the state of the patient's integrity, comfort, and functional capacity, and the patient's perception of this state as it is maintained or recovered (Lomborg & Kirkevold, 2005, 2006). Well-being and health are often used synonymously when one is not ill. Thus, staff well-being is also important to creation of a healing environment for patients.

Transition is the process humans undergo when faced with changes in their lives or environments and results in internal responses to the flow and movement involved (Meleis & Trangenstein, 2010).

Dignity is one factor that promotes healing and the healing environment. Communicating dignity and respect establishes the nurse's concern for the person, the patient, in his or her current circumstances, as well as his or her worth and value (Anderberg, Lepp, Berglund, & Segesten, 2007; Erickson, 2007; Gallagher, 2004; Price, 2009).

Holistic care offers the patient both traditional Western medical approaches and complementary, creative approaches toward healing, and creates the space for these approaches to be used while in and out of the hospital (Findlay et al., 2006). Erickson (2007) emphasizes that *holistic* care of the person requires consideration of the contextual specifics which uncover and illustrate the client's view of their world. Holistic care is defined as connection with the patient's desire for healing and meanings of the present situation, and actively partnering with the patient in their quest for healing. For Erickson (2007) and holistic care nurses, this connection is dependent on opening and alignment of energy fields "to facilitate synchronization of the two fields" (p 155). In contrast to a holistic, contemporary view of the person as an energy-based being is the wholistic Christian view of the person as a spirit-centered being.

O'Brien (2014) uses the "holistic" spelling and infuses the language of "holistic nursing" with the reality and presence of God, a personal divine being, as opposed to an impersonal source or other. O'Brien's understanding of the person as a spiritual being with a physical and psychosocial nature is reflected in her theory of spiritual well-being

in illness. This is consonant with the uniquely Christian view of *wholistic* care. Holistic will be used as it is reported in the literature. Otherwise wholistic will be the term used to reflect the uniquely Christian view of whole person care. The spelling of wholistic reflects “whole” person care. This is the context of care in the faith-based hospitals used in this study. Thus, these terms are connected by the root word, as well as the theistic belief system in which the terms are located.

Spiritual care is defined as the interactional relationship of nurse and patient having three overlapping components: the ministry of presence, the ministry of word, and the ministry of action (Carson, 2011). Spiritual care that excludes a transcendent other, God, would have overlapping human components of presence, word, and holistic action, whereas spiritual care that includes a transcendent Other (God) is noted as wholistic. This difference is rooted in *whole* person care which can be based in either human-centered *holistic* care, or God-centered wholistic care.

Spirituality allows inclusion of those with or without religious convictions and is encompassed by the descriptive definition of Fowler & Peterson (1997):

Spirituality is the way in which a person understands and lives life in view of her or his ultimate meaning, beliefs, and values. It is the unifying and integrative aspect of the person’s life and, when lived intentionally, is experienced as a process of growth and maturity. It integrates, unifies, and vivifies the whole of a person’s narrative or story, embeds his or her core identity, establishes the fundamental basis for the individual’s relationship with others and with society, includes a sense of the transcendent, and is the interpretative lens through which the person sees the world. It is the basis for community for it is in spirituality that we experience our co-participation in the shared human condition. It may or may not be expressed or experienced in religious categories (p. 47).

This definition describes ways in which one's worldview influences and directs the choices, values, and behavior of the nurse giving spiritual care, and the patient's unique spiritual concerns in being partner-recipient of that care.

Compassion is the attitude and action of the nurse showing empathetic concern and ability to suffer with the patient in the circumstances of their illness and journey towards well-being. The attitude reflects one's intense inner feelings that leads to action, that is, outward compassionate acts of mercy and kindness (Elwell & Comfort, 2001). Dossey (2010) adds that compassion is based on the awareness of the vulnerability and fragility of the human condition.

Intention refers to the nurse as purposefully engaging or partnering with the patient's desire for healing whether from a holistic energy basis or Judeo-Christian wholistic basis.

APPENDIX B

SEARCH TERMS USED AND DATABASES ACCESSED

PRIOR TO DATA COLLECTION

Data Base	Years Surveyed	Topic(s) HE & W-B, 0Wd	HE, W-B & NRes, 0Wd	HE & Nrsg, 0Wd	HE, Nrsg, NRes, & 0Wd
Academic Search Premier	1990-2012	8	2 but included rats, etc.	1	
CINAHL	1990-2012			0	(1 new one)
Medline	1990-2012	9 (5 new ones)	(0 new)	5	18 (15 new)
Pub Med	1990-2012	HE, 0Wd = 1539 HE, W-B, 0Wd = 628	Research = 221 ** Actual Research = 16 (5 new)	64	9** Actual research = 29 (7 new)
TOTAL = 33 research studies		r/t nurse or staff perceptions of environment			

Healing Environment = HE

Well-Being = W-B

Not Wound* or Bone = 0Wd

Nursing = Nrsg

Nursing Research = NRes

Nurses Perspective = NPrsp

**Many not actually research studies, but discussions and theoretical papers

APPENDIX C
CREATING A HEALING ENVIRONMENT: STRATEGIES
NURSES USE

Semi-structured Qualitative Interview Guide

Introduction: These questions are designed to learn how you create a healing environment and enhance well-being for your patients. Please know that there are no right or wrong answers. I desire as much description and story as you can provide. (*Italicized questions may be asked on the first interview or wait until the second depending on the direction the nurse takes the interview.*)

- a. For you, what is well-being and what contributes to the patient's recovery of health and well-being while here in the hospital? How do you define a healing environment? *Are there distinctions you would make between a healing environment and that which enhances well-being in the patient?*
- b. Describe how you create this healing environment. How do you do it? That is, describe your experience of walking through the 12 hours with this patient in a manner that facilitates healing for them? *How do you know when you're succeeding at creating this environment, when it's underway and going well?*
- c. Tell me about a time when you created a healing environment for one of your patients. Give as much detail as you can remember. Follow up, if necessary: What did you do? What did you say? What prompted you to give this specific care? *Was there anything else you did to create a healing environment or enhance the patient's well-being?*

- d. In your story about ____ (above patient situation) tell me about the strategies that guided you as you were facilitating the healing environment for this patient.
Follow up, if necessary: Are there any formulas or tips that you've picked up that help you respond to the client's need for healing and an environment which contributes to healing?
- e. Again, thinking of a particular situation, what are the outcomes of using these strategies? What do you see are the results of your efforts? How do you discern when something is a helpful strategy?
- f. Is there another story of your facilitating/creating a healing environment you'd like to tell?
- g. Can you think of a time when creating the healing environment didn't go as planned, or as you would have hoped? Tell me about that situation. What happened? What did you say and/or do? And why do you think this was a not-so-good example?
- h. What are factors that enhance the creation of a healing environment, or enhance well-being?
- i. What are barriers you've experienced to the healing environment and well-being?
- j. What determined whether you initiated creation of the healing environment?
Follow up: Are there instances where you don't initiate this process? and if so, tell me about that (your reasoning for not doing so).
- k. What advice would you give to other nurses about how to facilitate or create a healing environment for patients?

- l. Is there anything else you would like to add about how you facilitate or create healing environments?
- m. If the nurse HAS NOT shared stories that include spiritual care giving, then ask the question: What is your spiritual or faith-based background, and how do you express this in creating a healing environment that enhances well-being?
- n. What was this interview like for you?

APPENDIX D

CREATING A HEALING ENVIRONMENT: STRATEGIES

NURSES USE

“Information about You” Form

1. Gender:

Male

Female

Other (explain): _____

2. Age (in years) _____

3. Ethnic background [please specify]: _____

4. Nursing Educational background:

Associate degree

Masters Degree (NP & others)

Diploma program

DNP Degree

Baccalaureate degree

PhD Degree

5. Number of years practicing in nursing: _____

2. Work setting [please specify type of unit, specialty, ICU, or general medical, etc.]: _____

7. Average number of hours per week worked: _____

8. Average nurse-patient ratio when working: _____

9. Usual shift worked:

days (8 or 12 hour) evenings

nights (8 or 12 hour) other (explain _____)

10. With what religious tradition do you identify most? _____

11. Where, if anywhere, have you received information about creating a healing environment for patients?

nursing school

graduate education courses

on the job training

C.E.'s

other, please specify

12. Are you a certified holistic nurse? Yes _____ No _____

APPENDIX E

CREATING A HEALING ENVIRONMENT: STRATEGIES

NURSES USE

Fast Fact Sheet

Jane Pfeiffer, MS, MA, RN, Assistant Professor of Nursing, Azusa Pacific University, and PhD Nursing student, Loma Linda University, is the Researcher

Aim:

To obtain from nurse clinicians (identified as exemplary in creating a healing environment by supervisors or peers) descriptions about how they create a healing environment.

Methods:

Qualitative portion: once identified by a colleague or supervisor as possessing experience or expertise with creating a healing environment for patients

- Tape-recorded interviews with nurses (two interviews/nurse, ~ 60 minutes each)
- Location to be mutually agreed upon, convenient for nurse
- Interview questions designed to elicit stories and observations about their perception of creating a healing environment
- Data to remain confidential and anonymous, even though transcribed for analysis

Criteria for volunteer participation:

- registered nurse with at least two years of work experience
- work as a nurse an average of at least 10 hours per week
- work primarily with adult clients on non-end-of-life clinical units
- comprehend, read, and speak English
- agreement to participate indicated by signing the consent form

For further information, contact:

Jane Pfeiffer at (626) 857-2265 [office] or (714) 423-0590 [cell] or jpfeiffer@apu.edu

APPENDIX F

INFORMED CONSENT

Title: Creating a Healing Environment: Strategies Nurses Use

Sponsor: LLU School of Nursing

Principal Investigator: Patricia Jones, Ph.D., 909-558-7122

Purpose and Procedures:

The purpose of the study is to explore the strategies nurses use to create a healing environment to enhance well-being for hospitalized, non-end-of-life patients from admission forward. A maximum of 30 nurses total will participate in this study from two Southern California hospitals with 10 or more of those subjects at LLU/LLUMC. Your **participation in this study may last up to 6 months**. You must meet the following requirements to be in the study: registered nurse with at least 2 years work experience, work as a nurse an average of at least ten hours per week, work primarily with adult clients on non-end-of-life clinical units, comprehend, read, and speak English.

Participation in this study involves answering a few questions about who you are and about your nursing work. Next, a tape-recorder will be turned on and the investigator will ask you several open-ended questions about how you create a healing environment and enhance well-being for your patients. These questions will be provided to you beforehand in writing, if you desire, so that you can think about your answers. This face-to-face interview will likely take one to one and a half hours. After the interview is transcribed and the investigator has begun to analyze the information you provide, appointment for a second interview (within 16- 20 weeks of the first) will be sought. In this interview the investigator will clarify and validate her analysis and may have additional questions for you. The second interview will likely take not more than 30 minutes, sometimes less. Both interviews will occur at a time and place that you prefer.

Risks: The committee at Loma Linda University that reviews human studies (Institutional Review Board) has determined that participating in this study exposes you to minimal risk. Risks from participating could include tiredness from being interviewed or emotional discomfort in talking about how you create a healing environment to enhance well-being of patients.

Benefits: There are no benefits to you from this study. The knowledge gained from your participation will be used to inform nurses how to create a healing environment and enhance well-being in caring for their patients.

Participant's Rights: Participation in this study is voluntary. If you do not wish to answer a question, you can skip it and go to the next question. If you do not wish to participate you can stop at any time.

Confidentiality: The information you provide will remain confidential. Your name will not appear on the informational form or in the transcribed interviews. Any names that

you inadvertently mention during the interview will be substituted with “xxx” by the transcription service. Any published document resulting from this study will not disclose your identity.

Cost/Reimbursement: There is no cost to you for participating in this study. You will receive a small gift as a token of appreciation after you complete the two interviews.

Impartial Third Party Contact: If you wish to contact an impartial third party not associated with this study regarding any questions or complaint you may have about the study, you may contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92354, phone 909-558-4647, email patientrelations@llu.edu for information and assistance.

I have read the contents of the consent form and have listened to the verbal explanation given by the investigator. My questions concerning this study have been answered to my satisfaction. I may call Dr. Patricia Jones (Principal Investigator and dissertation chair) at (909)-558-7122 if I have additional questions. I hereby give voluntary consent to participate in this study. Signing this consent document does not waive my rights nor does it release the investigators, institution, or sponsors from their responsibilities. I have been given a copy of this consent form.

_____	_____
Signature of the Participant	Date

Printed Name of the Participant	

I have reviewed the contents of this consent form with the person signing above. I have explained potential risk and benefits of the study.

_____	_____
Signature of Investigator	Date

Printed Name of Investigator	

APPENDIX G

EMAIL SCRIPT TO BE SENT TO RECOMMENDED NURSE

PARTICIPANTS

Hello,

My name is Jane Pfeiffer, MS, MA, RN, a Ph.D. nursing student at Loma Linda University's School of Nursing. I am writing to tell you about my dissertation research study. The purpose of this study is to explore strategies nurses use to create healing environments and enhance well-being for hospitalized non-end-of-life patients. You are invited to participate because your nurse manager recommended you as a nurse with expertise in creating an environment for healing.

If you agree to participate, you will be asked to answer questions about your nursing practice and how you create this environment during two tape recorded interviews. The first interview will take about 60-90 minutes of your time, and a second interview of 30 minutes or less will be done within 4-6 months. You will not be paid for your participation in this study, though a small thank you gift will be given at the completion of interviews. Location and timing of the interviews are scheduled for your convenience.

Possible risks to you could include tiredness from being interviewed or emotional discomfort in talking about how you create a healing environment and enhance well-being of patients. Although you will not benefit directly from this study, we hope the results will help us learn how nurses create a healing environment and enhance well-being in caring for their patients.

Participation is voluntary, and your nurse manager will not know if you have chosen to participate in the study or not. Your decision whether or not to participate or to terminate at any time will not affect your employment.

You can contact me directly by phone or email if you have any questions about the study or your participation in it. My email is jpfeiffer@apu.edu, my phone is 626-857-2265 (o), or 714-423-0590 (c). Or you may contact Dr. Patricia Jones, 909-558-7122, if you have questions about the study.

APPENDIX H

TELEPHONE SCRIPT TO FOLLOW EMAIL SCRIPT

This is _____ from the office of Nursing Research and I am calling in follow up to the email you received last week about participation in a dissertation research study. The study is to explore strategies nurses use to create environments which help patients heal and return to well-being.

If they answer: Did you receive the email? Do you have any further questions about participation? If not, do you have interest in participating in the study and being interviewed? If so, would you please email jbacon@llu.edu of your interest, and if you include a phone number where you can be reached she will call to set a time and place for your first interview.

If the answer is NO: Thank you for your consideration. We will let Jane Pfeiffer know of your decision.

If an answering machine is the option:

This is _____ from the office of Nursing Research and I am calling in follow up to the email you received last week about participation in a dissertation research study. The study is to explore strategies nurses use to create environments which help patients heal and return to well-being.

If you have interest in participating would you contact the researcher either by email jbacon@llu.edu or by phone 714-423-0590 (c) or 626-857-2265. On behalf of the Office of Nursing Research and the researcher, thank you very much.

APPENDIX I
DATA ANALYSIS GRID

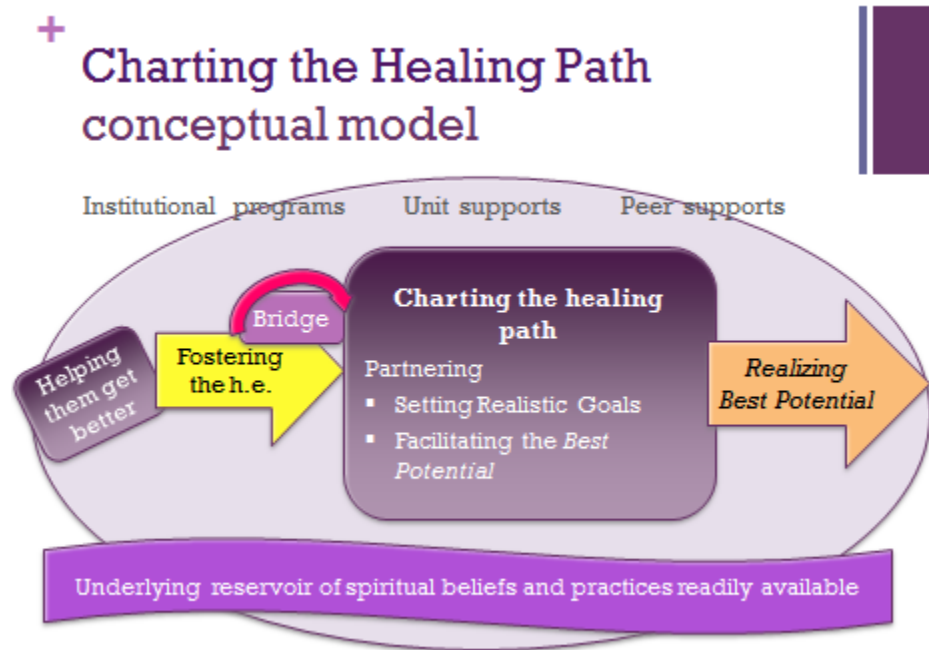
Definition of healing environment or well-being which included spirituality	9
Began with a spiritually focused exemplar	5
Number of patient situations reported	62
Patient situation with explicitly spiritual intervention	23
Sense of calling/passion	8
Advocacy	14
Vulnerability	11
Readiness Factor in nurse &/or patient	10
Voiced strategy of self-care	6
Did spiritual assessment	8
Gave example of Integration of spiritual care without labeling it "spiritual care"	7

APPENDIX J

CHARTING THE HEALING PATH MODEL

Figure 1

Charting The Healing Path Model



APPENDIX K

HELPING THEM GET BETTER CODING EXAMPLE

Nurse CC is one of 13 interviews and six researcher memos which generated 39 sources of **“helping them get better”** codes

NURSE CC: . . .then when I think the patient knows what our goals are and what we’re trying to do for them. They can then participate in that, and I think that can **encourage them to heal better**.

JP: Um hmm. And in knowing and participating there’s this sense of shared. . control if you will . .

NURSE CC: Absolutely. Yes, absolutely.

NURSE CC: a H.E.? I just feel like it’s one where you know the **patient’s needs are being met, and they’re getting better**, but also one **where they feel confident that they can deal with** whatever diagnoses or whatever illness that they’re dealing with. Maybe they’re not going to completely recover from that, but the idea **that they can deal with it**, and live a just quality of life type of thing.

JP: So, is there any difference between, or are there distinctions between a H.E. and that which enhances W-B in the patient?

NURSE CC: Um, I’m not sure about that. I think they would be much the same but I just feel like there’s a lot of things that we can’t heal, I mean there’s a lot of diagnoses and problems in patients, you know, for example diabetes. You can’t fix their diabetes but **you can help them deal with it and live a good quality of life**.

JP: So you can’t heal, but you can help them . . .

NURSE CC: Right. JP: . . . attain a sense of W-B?

NURSE CC: W-B, dealing with what they have to deal with, . . .just helping them to feel like “you know what? **I can deal with this**”. This is an issue I’m going to have to live with, and giving them the best tools to be able to live with that would be more the sense of W-B.

when I’m doing things with them, I am telling them what I’m doing. Um, you know, this is what’s gonna happen, this is what we’re going to do, this is how we’re gonna try to fix this, **help to make you better, and then this is what you can do to help me help you**.

Table 2

Examples of Clustering Codes for Substantive Area “Helping Them Get Better”

Excerpts of Nurse Conversation from Interview	Open Codes and Substantive Code*	Substantive & Umbrella Code**
<p>That would be another healing environment - giving them [pt. whose bag of water has ruptured] a sense of normalcy even while they’re here in the hospital is important. JP: Um hmm. And no small challenge. NURSE: Very difficult sometimes especially with some of the restrictions. You know, some are on bed rest. They can’t get out of bed much. You know, so we push it, once they get a little bit stabilized we push it, and they have a bedside commode. And the nurses are very proactive in that. Can we just have a bedside commode so she’s not in bed actually, she can’t walk to the bathroom but she can at least get up to a bedside commode.</p>	<p>Getting Up Out of Bed Relaxing the restriction</p>	<p>Helping them get better</p>
<p>I think I also helped treat his pain. Pain is difficult to always assess and to always medicate correctly. . . . So pain is important. Knowing the source of their pain, what helps their pain, the patients can’t heal if they’re in a lot of pain. So just helping manage his pain was another thing that I did.</p>	<p>Pain relief</p>	
<p>So if a patient we can’t, who had like a major head trauma, they can’t tell us if they’re hurting. They can’t, I mean maybe they’re not even moving, so we don’t know what’s going on. So we rely, if their pressure has increased a lot, ok, heart rate increased a lot, ok what’s going on with your</p>	<p>Pain relief in the comatose patient</p>	<p>Helping Them Get Better</p>

<p>blood pressure. Try pain medication. Does that calm it down? Yes it does, ok, so it's pain related. If it doesn't calm it down, ok, something else is happening. So we try, we go through a set process. We see what's going on – elevated heart rate, high pressures, blood pressures, increased breathing, agitation, moving around. So we look for other signs since they can't communicate with us verbally.</p>		
<p>Well the first thing you do in the morning of course you go over and introduce yourself, and make sure they know who you are and how to get a hold of you. I do my assessments right away too. I need to make sure they're all stable and everything is okay. Make sure they are not in pain, and if they are then we need to address it.</p>	<p>Introduction c baseline assessment</p> <p>Pain relief and comfort measures</p>	<p>Helping Them Get Better</p>
<p>JP: How do you approach the patient, in creating the healing environment.</p> <p>Nurse: I'll just go back to the combative patient I had earlier, which was not on my centered unit. I got the report from the nurse, learned all of her antics that had gone on the previous night and days, and . . . I went in and . . . I started explaining and introducing myself. Try to incorporate her into other things outside the hospital, like “do you think it's going to be a hot day outside”, where are you from, where were you born”, cause the patient had an unusual name, and it was a religiously tied name, so I knew there was something else. I found out that she had done a lot of traveling and it kind of brought her back in to the world so she could understand what was going on. . . through the progress of the day being able to draw her back</p>	<p>Patient-centered healing environment</p> <p>Reality-oriented communication</p>	<p>Helping Them Get Better</p> <p>Communication Strategies</p>

<p>into the reality, explain what was going on, what was happening. You could see that transition.</p>		
<p>What are other things you did with her that created that sense of healing in an ongoing way. NURSE: Let's see. For that particular patient culture was really important and the way they do things, and the way they kept their environment. I know that she liked food from outside of the hospital and as soon as you just teach them as long as it's under your diabetic cardiac diet, it's ok to bring it in. So I was just going based on her culture as well, and I think that's healing to them cause that's what they're used to. I think that if they're in the hospital with a major surgery and it's just things that they're not used to it will take longer for them to heal.</p>	<p>Pt-centered healing environment Culture Care and Familiarity</p>	<p>Helping Them Get Better</p>
<p>I mean the simple things, 'here's your call light, just push this and I'll come. Let me know any time and I'll be in here and then we tell her, you know, we're watching those monitors out in the thing. If I see something with your baby that concerns me I will be in the room. So different reasons why I would come in. . or you know how to call me.</p>	<p>Available to meet patient needs</p>	<p>Helping them Get Better Available to meet patient needs</p>
<p>And I went in and I wasn't the primary nurse but I went in to help the nurse because we could tell that we needed to do something quick, but we didn't know what. And so we called the doctor and the resident came in and the wife was at the bedside, and he just looked at him and he didn't know what to do either. He had tons of lines, he had this PA line catheter in his neck. His blood pressure was stable</p>	<p>Available to meet patient needs Vulnerability on part of nurses, residents, and patient and wife</p>	<p>Helping Them Get Better Available to meet patient needs</p>

<p>but it was starting to dip down and his heart rate was going up higher, and we just, we didn't know what to do and then we called the resident and then he called the fellow and he's like, ok let's try some other drip slips, give him something to calm him down and maybe we just. . we were at wits end. The wife was there and she was crying and we were all. . we just . . it was just so difficult because we didn't know what to do. We wanted to help him but we didn't know what to do.</p>		
<p>I usually come in, I try to go in about every hour whether I have something or not, just to check up on them, just to see, just to pop in my head and say "hey, everything ok? You need anything? Alright. Moving on", and try to bulk most of the things if possible, you know, in one hour rather than coming in every ten or fifteen minutes or so.</p>	<p>Available to meet patient needs Consolidating Care</p>	<p>Helping Them Get Better</p>
<p>What is a healing environment as you understand it? NURSE: I think it's also really important to have a nurse that's very compassionate, because if you show that compassion, I think, I really believe that they are able to heal quicker. That's what I think. So I try to be really attentive to them. I try to be as nice as I can to them. I think it's important.</p>	<p>Attentiveness Available to Meet Patient Needs</p>	<p>Helping Them Get Better</p>
<p>How do I end [the shift] . . . I make sure I left everything organized; everything's been done. The room is clean, as neat as I can leave it. Make sure that I addressed all their needs. I always, throughout the shift, I'm always asking them "is there anything else I can do for you?" If they don't have anything that they need at that point, "please</p>	<p>Nurse Attitudes Facilitate a Healing Environment Available to Meet Patient Needs</p>	<p>Helping Them Get Better</p>

<p>call me if you need something”. And I thank everybody at the end of my shift, “it’s been a pleasure being your nurse, thank you so much”. Sometimes I’ll ask them “is it ok if I give you a hug?” [laughs] .</p>		
<p>. . . make a connection with my patients. I really always try to go above and beyond because I really want to start out the day well, cause if you start off a day on the wrong foot it’s hard to play catch up, so I’ll take the time and make them comfortable, make sure they have no pain or anything like that and anything I can do to alleviate that.</p>	<p>Comfort measures Make a Connection Available</p>	<p>Helping Them Get Better</p>
<p>There’s a lot that you’re going through and your doing your assessments and your, all your systems and that kind of stuff but really having that conversation with them where you can. . . I know your busy multitasking and doing a lot of things but having that assessment piece, and some of it comes with time, and developing that technique, multitasking and conversing at the same time. A lot of times it’s the opening statement. “How was your night?” Or just things where you can draw them in to connect with them. “I heard you had a rough night last night. Is there anything that I can plan to make your day better?” Or you know, it’s usually that first impression. You don’t want to leave them with “I’m too busy for you”.</p>	<p>Doing Baseline Assessment Open Ended Questions Communication Available</p>	<p>Helping Them Get Better Doing Baseline Assessment Available to meet patient needs</p>
<p>A healing environment, as I see it, is one that I think quiet, quiet is good, although quiet in the hospital setting is very difficult cause you have so much activity . . . so we do strive to create a healing environment by lowering our voices, keeping it quiet, sometimes just resting in darkness,</p>	<p>Quiet and Rest</p>	<p>Helping Them Get Better</p>

<p>to allow the body to rest, cause some people - in today's society we are just go go go go go, . . . and we don't take the time, as God's prescribed for us specifically to rest</p>		
<p>what contributes to that good environment in the patient's recovery of health and well being while they're in the hospital? NURSE: Um, I think it's really important to allow them to rest. So try to, if you need to do anything with them, try to cluster everything. Try to do as many things as you can at once and then let them rest,</p>	<p>Consolidating Care Quiet and Rest</p>	<p>Helping Them Get Better</p>
<p>how do you define a healing environment? Nurse: It's more or less tied to the previous answer regarding that, you provide all the answers, you support the patient and the family, that way they actually feel like they are safe. If you don't feel safe you're not gonna heal if you don't understand what's going on.</p>	<p>Education Patient/Family Feeling Safe</p>	<p>Helping Them Get Better Education & Communication</p>

*At the beginning of analysis all codes here were open codes, and **Doing Baseline Assessment and Being Available** later became **Substantive Codes**

****Helping Them Get Better** was the umbrella substantive code. Others were categorized as part of this code

Table 3

Examples of Clustering Codes for Substantive Area “Fostering the Healing Environment”

Excerpts of Nurse Conversation from Interview	<i>Open Codes in italics</i> Consolidating of Codes in regular type & Bolded*	Substantive Codes ** in creating a healing path model
<p>“Are your numbers always this high?” And, but I think it’s important and instead of immediately lecturing them, which I can do as well, is to hear their side and so I let him talk. He liked to talk, and he explained how when his sugar gets low, he doesn’t pee, and I was like, “really”? He says “yes, it’s a big problem and I know my body and you guys come in here and mess up my insulin regimen”.</p>	<p>Hearing Patient’s Immediate Concerns →</p> <p><i>Listening/Communication</i></p>	<p>Fostering the Healing Environment (H.E.)</p> <p>Hearing Patient’s Immediate Concerns</p>
<p>Went on a fishing trip with his buddies, and ended up getting some cut on his finger from fishing and all this kind of stuff. He came back and wasn’t feeling so well and ended up getting super septic and having a whole bunch of other issues. . . we just created a really good friendship as well. We were able to find out about each other’s lives and he was very scared or very nervous so I think the way that I would come off in helping him and encouraging him and just giving him extra love and attention really was so nice for him.</p>	<p>Knowing as a Unique Individual →</p> <p><i>Knowing the person</i></p> <p><i>Meeting emotional needs</i></p> <p><i>Developing the relationship</i></p>	<p>Fostering the H.E.</p> <p>Knowing as a Unique Individual</p>
<p>You mentioned help them feel like you’re family. How do you help someone feel like they’re family? NURSE: When I approach them, I approach them as if I</p>	<p><i>Developing the relationship</i></p> <p><i>Treating them like family</i></p>	<p>Fostering the H.E.</p> <p>Knowing as a</p>

<p>know them, as if I've known them before. I try to use terms that apply to their age level, or something they could relate to. I use a lot of humor, and that just right off the bat makes a difference when you use humor. And it's not a phony humor. It has to come natural, and I think that when you approach a patient with a positive attitude they feed on that, and it helps them feel a kindred spirit there.</p> <p>And then I too, often try to find out a little bit about their personality. Maybe their likes, dislikes, and then something that really means a lot to them at the moment. . .</p>	<p><i>Humor</i></p> <p>Knowing as a Unique Individual →</p>	<p>Unique Individual</p>
<p>As far as a nurse, and the patient having needs from me, things that I can offer. Providing education, what to expect, to help decrease their anxiety. That contributes to their health and well-being. And articulating it in a way they can understand. Then, also having a concept or confidence that can help them communicate their needs and also being able to give them access to other areas they might need. For example, because I was a charge nurse, I had knowledge or access to different things they needed, referrals, resources that they needed. I had confidence in myself, and I was able to convey that confidence because I was able to get access to those resources that they needed. Or the attitude, If I don't know I'll try to find out.</p>	<p><i>Nurse Anticipating Patient Needs</i></p> <p><i>Offering Self & Resources</i></p> <p>Nurses Point of View →</p>	<p>Fostering the H.E.</p> <p>Seeing from Nurses Point of View</p> <p>Education Strategies</p>
<p>So as nurses you hear a lot of different theories and patients come with a lot of their own theories as to why they have this disease, or why blood sugar is high, or different things and so on the cardiac floor, you know, we do a lot of education which is important. But I think it's also important as nurses to know where they're coming</p>	<p><i>Nurse Attitudes Facilitate a Healing Environment</i></p> <p>Seeing from the patient's point of view →</p>	<p>Fostering the H.E.</p> <p>Seeing from the patient's point of view</p>

from and to not just completely disregard their theory,	<i>Communication & Education Strategies</i>	
And so sometimes you hear things patients say and you just completely throw it out the window thinking you know, what, like I'm the nurse here and I should know. Yes, but you work with them, you work with them so that you're able to at the end of the day to teach them more because you have built their trust.	<i>Nurse Attitudes Facilitate a Healing Environment</i> <i>Building Trust</i> <i>Communication & Educations Strategies</i> <i>Seeing from the patient's point of view →</i>	Fostering the H.E. Seeing from the patient's point of view
Kinda put yourself in their shoes if, you know, you were in that situation or that was your family member or what you would like..	<i>Availability</i> <i>Treating them like family</i>	Fostering the H.E.
I often tell them I have knowledge you may not have, and I'll share it with you. But I'm just a woman with a family, and with feelings that get bent out of shape, and get tired, like you. I often try to find something in common with them. Who doesn't want to show you pictures of their kids, or grandkids, and I'll show them mine. Who doesn't have favorites or preferences for food, or reading, or music? Or find something we have in common and build on it. Then that opens to a deeper level of communication. Something more personal and intimate.	<i>Availability for relationship</i> <i>Knowing the Patient as a Unique Individual →</i> <i>Communication Strategies</i>	Fostering the H.E. Knowing as a Unique Individual
I think another key as aspect of creating a h.e. is bring spirituality in. I think we are all created as spiritual beings whether some recognize it more than others, but that purpose and that hope that I mentioned in the beginning is	<i>Integrate spirituality</i> <i>Purpose</i> <i>Spiritual Awareness</i>	Fostering the H.E.

<p>in every single human being – that purpose for life, that question of meaning, where are we going, where did we come from. I think it's inherent in everybody and really connecting with the patient where they are, and helping them to see that there is hope and joy and meaning in life. It's very important in creating a h.e.</p>	<p><i>Connecting with the Patient's Point of View of Spirituality</i></p> <p>Spiritual Strategies</p>	
<p>When the patients don't trust you, they're not gonna listen to you, or care about anything that you say, so it's really building that trust with the patient that's really important.</p>	<p><i>Trust</i></p> <p>Seeing From the Patient's point of View →</p>	<p>Fostering the H.E.</p> <p>Seeing from the patient's point of view</p>
<p>So I think you really have to read the patient and what their needs are and maybe sometimes you know tweak things to get them . . . talking and telling us</p>	<p><i>Read the patient's Needs</i></p> <p>Seeing the Patient's Point of View →</p>	<p>Fostering the H.E.</p> <p>Seeing from the patient's point of view</p>
<p>So, sitting on the edge of the bed, and usually I can test whether the patient has spatial issues that way. Most of the time if I just "go for it", and sit on the bed. If they start to get nervous and/or pull away/move back, then I'll stand up and just kind of play it off, do something to distract that. But most of the time, 99% of the time they don't move. So, I can kind of see that they're letting me in.</p>	<p><i>Physical Proximity</i></p> <p><i>Read the patient's Needs</i></p> <p>Seeing from the Nurse's Point of View →</p>	<p>Fostering the H.E.</p> <p>Seeing from Nurses Point of View</p>
<p>There has to be a lot of empathy and insight, patience and you have to be a good listener I think. You have to be able to feel what the patient is feeling and accept them as an individual. That's huge, 'cause there's a lot of stereotypes</p>	<p><i>Empathy/Communication</i></p> <p>Seeing from the patient's point of view →</p>	<p>Fostering the H.E</p> <p>Knowing as a Unique</p>

<p>that go on in nursing and to be able to just look at them as an individual is important I think as far as grasping their needs.</p>	<p>Knowing as a unique individual →</p>	<p>Individual</p> <p>Seeing from the patient's point of view</p>
<p>Why do you open the blinds? What's behind that? NURSE: For me, I think it's the light. I love the light, um, but I think for the patients it's good for them to know what's going on outside rather than just - especially if they're here for any length of time. We have a patient now who has been here for a long time and we finally got her privileges to actually go outside and walk two or three times a day to just get out of that room and see what time of day it is, and I think that's [healing] . . .</p>	<p><i>Nature</i> <i>Healing Garden</i> <i>Light</i></p> <p>Seeing from Patient's point of view</p> <p>Seeing from Nurse's point of view</p>	<p>Fostering the H.E</p> <p>Seeing from the patient's point of view</p> <p>Seeing from Nurse's Point of View</p>
<p>so if the nurse from the nurse's point of view cannot connect with this (the patient's point of view), then we have another barrier. .</p> <p>JP: I thought that was insightful, and you illustrated it. So I think I probably need to put that in.</p> <p>Nurse: Yeah, that's a big one too. At least that's what I see as far as like nursing-patient failure is when the nurse 1) either overreacts and/or 2) is so task oriented that they missed the cue. Cause patients will give off a cue and they're so, I mean, like I had a lady whose husband was dying of mets (cancer) and she wasn't my patient, but I, or he wasn't my patient but I was engaging with her because nobody else was. She kept coming out to the nurses station, coming out with questions, coming out with</p>	<p>Seeing from patient/family point of view →</p> <p>Seeing from nurse's point of view →</p> <p><i>Juncture of the two</i></p> <p><i>Family Needs</i></p> <p><i>Responsive or Unresponsive nurse</i></p>	<p>Fostering the H.E</p> <p>Seeing from the patient's point of view</p> <p>Seeing from Nurse's Point of View</p>

<p>concerns and I kept talking with her and talking with her and her nurse just said “well we’ll call the doctor and we’ll look into that. It’s like part of me said “are you kidding me? This lady is like on the edge, she’s losing her husband. She has no support, she has no kids and this is it.</p>		
<p>Others: Getting to know the patient → Presence, Listening, Touch, Humor Hearing immediate needs → Encourage expression of emotion Seeing from the patient’s point of view → Clarifying Expectations <i>These codes could apply to any of the above categories</i> Family member needs Offer reassurance Negotiation of Interdisciplinary Services on behalf of patient</p>	<p>Knowing as a Unique Individual →</p>	<p>Fostering the H.E Knowing as a Unique Individual</p>

Consolidated Codes** in regular type include *open codes* which were later merged, renamed or consolidated to form substantive codes in this same column. When the substantive code is both an *open code* which retained its name when later consolidated, that is indicated by ***bolding and italicizing the code. So by the fifth nurse interview many of the Fostering the Healing Environment (H.E.) categories were identified and would therefore be coded as a **substantive bolded code**. The → indicates the code moved from the first levels of coding and consolidation to the Substantive Category unchanged.

Table 4

Examples of Clustering Codes for Substantive Area “Charting the Healing Path”

Excerpts of Nurse Conversation from Interview	Codes which were consolidated (as indicated by →) to populate the Substantive Codes*	Substantive Umbrella Code **
<p>One of the things I do tell my orientees or my new nurses is go in with a blank slate. Don't go in with any preconceived notions about what the patient is in. Let your interactions with them dictate how the day goes, because, just because somebody else had a bad night doesn't mean you need to have a bad day. And you know, so not having that judgment, assessing the patient's needs, and working towards mutual goals keeping them involved being a patient advocate, and with the doctors in facilitating their care, definitely having them be advocates, promoting health, advocates for their own health, and education 'cause a lot of times they need that reinforcement to help them manage their own well-being.</p>	<p>Advice for new nurses Advocacy → Partnering with the Patient Setting Realistic Goals Self-Care Manage Own Care</p>	<p>Charting the Healing Path Outcome</p>
<p>[Well-Being is] dealing with what they have to deal with, making it, you know, the best that we can, but also, just helping them to feel like “you know what? I can deal with this”. This is an issue I'm going to have to live with, and giving them the best tools to be able to live with that would be more the sense of W-B.</p>	<p>Confidence in Self-Care Ability → Facilitating Best Potential</p>	<p>Charting the Healing Path</p>

<p>If you say you're going to do something, follow through. If you make a plan for the day make that your plan for the day and follow through with it because the last thing they need is somebody who is taking care of them they feel they can't trust. "You said you were going to be here in an hour, why are you not here? I have pain issues". . . . Acknowledge that you're not there when you said you would be, and explain why. Those kind of things help them to be part of their care or feel like you know that their needs are being met and they in that process can have a better healing environment. Because sometimes they feel like, patients feel like they lack control in having a healing environment.</p>	<p>Advice for new nurses Nurse Follow Through Vulnerability →Partnering with the Patient</p>	<p>Charting the Healing Path</p>
<p>I'll ask mom if she plans to nurse (breast feed), and educate her in the process about her milk supply, that that often takes 5 – 10 days for the milk to come in. But the colostrum at the beginning is so rich with nutrient that it's enough for the baby. And baby's know how to nurse, they already know. So, I'm trying to give them the idea it's not so difficult. And we have lactation consultants if they need. I'm helping mom understand what's going on, educating. . . and encouraging . . .</p>	<p>Mother-Baby Education Power of Imagination toward Healing →Partnership For Health ***</p>	<p>Charting the Healing Path</p>
<p>Last week we had a baby who was born and very distressed, and the baby was going to transfer to another hospital and this was all very quickly after delivery, within a few hours and the mom very young mom, young dad, you know they had no idea, you don't anticipate. It was a full term baby, and things just went bad at the end. And</p>	<p>Seize the moment Advocacy Negotiation with interdisciplinary services</p>	<p>Charting the Healing Path</p>

<p>she was in her room, cause it had been a crash C-section. So she couldn't get into a wheel chair and they were going to leave. Originally the plan was to bring the isolette with the transport team into her room so she could see the baby before they went. But the baby was too unstable. So I got baby tech and we went . . . I got the tack, we went in, put the side rails down, unplugged the bed from everything and we just whipped her right in there in the middle of ICU, right there, so she could be there and see her baby. I asked the nurse, there was the transfer nurse, "can she touch the baby?" So she let her, she opened the door and let her reach in and touch the baby. I think it was really important because the mom, sometimes they have no idea how sick the babies are.</p>	<p>on behalf of patient</p> <p>→Partnership on behalf of the patient***</p> <p>Setting realistic Goals</p> <p>Facilitating best potentials</p>	
<p>We kind of negotiated a little bit, and I said "listen, this is just her time until we get these other patients delivered, if you can just hang in there with me", so kind of just getting her to work with me in this situation that presented itself . We then negotiated, cause she really needed a shower, so I took her upstairs and got her out a little bit and got her into the shower, you know, get her doctor's orders and stuff, but just kind of negotiated that. Got her out of the unit for a little bit, it was kind of crazy. So I think just working with her, what I thought might be better and it was funny because even getting her up and about, her blood pressure ended up decreasing after we got her showered and got her back in her room.</p>	<p>Negotiation with the patient</p> <p>Negotiation with interdisciplinary services on behalf of patient</p> <p>→Partnership with the patient</p> <p>Setting Realistic goals</p>	<p>Charting the Healing Path</p>
<p>Referring to a post-op open heart surgery patient who , culturally, expected family would do everything for him.</p>	<p>Family as Support or Barrier</p>	<p>Charting the Healing Path</p>

<p>Nurse: The patient didn't want to do anything. He didn't want to do anything. Um, so but, when I got the family involved to help then he was more active in participating. So it worked out smoothly; it just kinda took that little bump of like talking to the family and getting them a little bit more involved in the way I needed them to be involved instead of just taking over.</p>	<p>Education</p> <p>→Partnering with the Family and Patient</p> <p>Setting Realistic Goals</p>	
<p>It fell to the night nurse to respond to the patient's demand to talk to a senior resident or an attending, because he didn't what was going on and why he was still in the hospital. . . so I said "Look, I will call." . . . the resident said "I need you to smooth this over for me." And I said "you know what, she knew that I could make her look really bad or really good and I said "I will do that for you this one time but you have to make me a promise: that you will show your eyes to him in the morning. Not an intern, not a lower resident, but that you yourself will go and see him and address his concerns."</p>	<p>Advocacy</p> <p>Negotiation with the patient</p> <p>Negotiation with interdisciplinary services on behalf of patient</p> <p>→Partnership with the patient</p> <p>Setting Realistic goals</p>	<p>Charting the Healing Path</p>
<p>So, having that knowledge base and sharing that with the nurses and with the patient's family and with the patient too is very important so that they know that in those moments that your're, although you may be scared, that you know your role and you understand what's happening and what's going on.</p>	<p>Communicating Competence</p> <p>Drawing the team together</p> <p>→Partnering with the patient</p> <p>Best Possible Outcome</p>	<p>Charting the Healing Path</p>
<p>Generally we like to go a little slower [on insulin</p>		<p>Charting the Healing</p>

<p>adjustments] and take this deeper side which is, which is fine but also letting the patient be a key player when they are knowledgeable about their disease and when they are knowledgeable about their medication and letting them be involved with the care. It's important .</p>	<p>Honoring the Patient's Knowledge</p> <p>→Partnering with the Patient</p>	<p>Path</p>
<p>It depends not only on who the individual is, but what you're helping to facilitate. So for instance in nursing, a lot of it would be kind of understanding the baseline of what's going on with them, and what needs to be further developed to ... You know a lot of our patients could be immune-compromised and that kind of stuff, so helping to facilitate that towards its best potential, but at the same sense understanding their baseline. If they're, have chronic issues, want to get it to it's best potential, if that makes sense.</p>	<p>Setting realistic goals</p> <p>Facilitating Best Potentials</p>	<p>Charting the Healing Path</p>
<p>To me, that next level of health is just allowing that person to, to really heal and help them and assist them into being independent outside and knowing what they need to know to actually take care of themselves and be healthy in terms of what their goals are.</p> <p>It's just assisting them, guiding them, shedding the light, showing them the light. This is, you know, where you need to go. This is the path you need to take in order to get to your goal. And just helping them, and not doing it for them, but letting them know, I can help you. This is what the tools are that you need to actually achieve that goal.</p> <p>And I think that's a big part of it. . . And I tell my patients "don't be afraid to be different. Don't be afraid to be unique. Don't be afraid to be individual. Allow yourself</p>	<p>Next Level of Health</p> <p>Light</p> <p>Promoting Independence</p> <p>→Partnering with the Patient</p> <p>Self-Care Knowledge</p> <p>Self-Care Management</p>	<p>Charting the Healing Path</p> <p>Outcomes</p>

to exceed on your terms, on what you believe as success and achievement.”		
Having the faith and hope in my beliefs as a Catholic, having that faith and hope in my family, in the values that’s actually been bestowed upon me by my parents, and believing that that’s the right thing and I can share that with the people I actually take care of [not verbally] and that really helps, that really, really helps to let me know and understand that the confidence I have in myself and my skills are the tools that I can use to actually help create faith and hope in themselves and allow them to progress to that level of health.	intersection of personal spirituality and H.E. work Nurse Confidence Promoting Faith and Hope in Patient Spiritual → Partnership with the Patient	Charting the Healing Path

*The normal tone codes listed first in each column are the codes that became consolidated as indicated by the

➔ to the left of the **Substantive (Bolded) Code**

** **Charting the Healing Path** is Both the **Core Category** and the umbrella grouping for the following substantive codes: Partnering with the Patient Toward Well-Being, Setting Realistic Goals, and Facilitating Best Potential (bolded in the center column). Where Self Care and Self-Care Management are listed they may be goals as well as Realizing Best Potential Outcomes.

*** These examples from Labor and Delivery demonstrate partnership in an altered fashion from other units. But they qualify as partnering with the patient for well-being..

Table 5

Examples of Clustering Codes Related to Spirituality

Excerpts of Nurse Conversation from Interview	Initial Open Code	Consolidated Category Code
But if the patient doesn't believe or says he has no beliefs, I just keep on caring and I pray. Everybody gets prayer. I'm one of those VIP nurses – you know, we get the training to be with the patient, and staff.	Intersection of personal spirituality and H.E. work	Spiritual Strategy Spiritual Awareness, Prayer (after assessment)
I love to go to work. . . I don't think of it as a job. It's a calling. It's what I'm meant to be . . . I am passionate about this is my work, this is what I'm meant to do. This is where Jesus lives his life through me. This is where people meet Jesus in me. . . . I mean birth is such a joy, that there's often a way for parents to consider what is happening here	Nursing as Calling Nurse Awareness of Spiritual Dimension of Current situation	Nursing as a Calling Nurse Awareness
there's opportunities to do it [pray out loud] more and that sometimes patients are gonna, not all of them will blatantly ask you "will you pray for me?" so sometimes we need to be the initiator of that and offer it more often.	Nurse response to spiritual sharing	Spiritual Intervention of Prayer Nurse Awareness
Towards the end of the day I . . . tie up some, close some ends there and offer them a prayer, if appropriate at that time,	Nurse's use of prayer	Spiritual Intervention of Prayer

<p>PP: I had a patient that was Buddhist and I was like “can I pray for you?” And I wasn’t sure how open he would be with that, and not knowing a lot about Buddhism, but he was very open to it. But no, actually I don’t think I have yet . . . had anyone say that they didn’t want to pray.</p>	Nurse’s use of prayer	Spiritual Assessment and Intervention of Prayer
<p>So I stayed and it was like 45 minutes more or something. She delivered and her baby did end up going to NICU, so again we had another conversation in NICU, and just talked about, you know, things were going well. Her first baby was fine, we just prayed that things will go well, like it did with your first baby</p>	Offering reassurance (prayer as part it)	Nurse Awareness Prayer as a Part of Intervention
<p>[Nurse was pt on unit she works on after a miscarriage and talked about what was meaningful to her] So, now I do that with my patients. I give them permission to be angry, to be angry and sad. I don’t give them any false promises of what’s to come, or what’s going to happen. I don’t do that because (crying) you’re not ready to hear it in that moment. But I can pray that their heart won’t hurt anymore.</p>	Partnership with God for the patient Presence	Nurse Vulnerability , Spiritual Awareness, Spiritual Intervention of Listening (presence), Conversation and Prayer
<p>you have to just put yourself on the back burner and say “Ok, Lord, obviously I didn’t just get this patient without a reason.” And so you go in and say “give me the strength and He does give me the words and He does, and there it is. So now, I don’t allow external environment to influence that flow . . . all of that just goes by the wayside and you just focus in because it’s not about you,</p>	Partnership with God for the patient	Spiritual Awareness, Spiritual Intervention of Conversation and Assessment

it's about the patient and you just do your job.		
It [journaling} is huge, because it's helped me think more in depth about how it's really not me, and how I'm being used as a tool. . . . But when you read these stories back, when I read them back it's just reinforces the fact that it's not about me. . . . It doesn't matter because I'm doing what I'm supposed to be doing. There's a higher calling, there's a higher power there beyond what we see, and we have to remember to be in tune with that	Prayer of Use me Lord Journaling Practice	Spiritual Awareness
I can be the healing hands of God for you. Like I, sometimes I think about that too, when I'm taking care of my patients and I don't know what to do, I just pray God give me your healing hands to help this patient because I don't know what to do.	Prayer of Use me Lord	Spiritual Awareness Spiritual Intervention of Prayer
I'm not one to express my spirituality openly for my patients unless they're asking for it or speaking of it or bringing it up in conversation. For myself before I even start my shift I usually try and like, before I get into work or while I'm walking I kinda say a quick prayer over myself and over everybody that's working and my patients. And then just to prepare myself for the day, for myself.	Personal Spiritual Preparation Following the patient's lead	Spiritual Preparedness and Readiness Open to Conversation & prayer if patient initiates
so things that DO foster a healing environment is having a sense of joy, I think joy plays a huge role in healing. I'm a firm believer in the Bible and God and there's a verse that says 'The joy of The Lord is my strength.' And so I always try by	Nurse attitude facilitates expression of spiritual commitment	Nurse joy as preparedness

God's grace to infuse joy in my patients at this time.		
So, working on the floor, you know you have ups and downs in your days but coming in I always pray when I first come in, going up the elevator, you know, walking into our unit and just saying "Lord, use me today in your service". And coming in and just having a bright smile and saying "good morning," introducing yourself, "my name is A. and I'll be your nurse this morning", "how are you feeling today?".	Nurse Preparation Prayer of Use me Lord	Nurse Preparedness
Excerpts of Nurse Conversation from Interview	Open Code (Initial Code)	Consolidated Category Code