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# Patient Satisfaction with Nursing Care Related to Hospital Magnet Designation

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# Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Sharon Haylett

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Walden University  
2019

Abstract

Patient Satisfaction with Nursing Care Related to Hospital Magnet Designation

by

Sharon Haylett

MSN, Loyola University New Orleans, 2010

MPA, Cleveland State University, 2004

BA, University of Central Florida, 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

Walden University

May 2019

## Abstract

Many U.S. hospitals have historically failed to recognize nursing as essential to quality of care. Given the relationship between the patients' experiences, measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and government reimbursement, stakeholders now value the role of nurses in the care experience. Some hospitals have pursued Magnet designation, which is a rigorous and costly process, in order to promote patient satisfaction through nurse autonomy and retention. The purpose of this study was to understand whether non-Magnet hospitals received similar HCAHPS scores. Expectancy disconfirmation theory provides a framework to understand the components of patient satisfaction within the context of organizational structures and norms addressed by the Bourdieu theory of cultural health capital. A quantitative study was conducted using secondary data from a stratified random sample of 317 non-Magnet hospitals and a purposive sample of 317 Magnet hospitals. Chi-square tests of independence were performed; Magnet designation was significantly related to nurse communication, pain management, timely responsiveness of care, explanation of medication, and willingness to recommend. Magnet designation consistently had a higher proportion of 3-star and 4-star ratings compared to the tendency of non-Magnet hospitals to be more normally distributed across all five ratings. Study results, combined with the climate of patient consumerism, provide the social impetus for healthcare improvement specialists to promote social change through Magnet-like culture and protocols using an evidence-based practice outcome approach to champion better care experiences through empowerment of both patients and nurses to match expected care with delivered care.

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## Dedication

This dissertation is dedicated to my family -- most of all, Aliciana and Earl. Without the support from both of you, my doctoral journey would have been lonely and without laughter. This has been a long and arduous journey. I thank everyone who has given me a supportive and encouraging word along the way. Next, I would like to thank my friends -- most of all, Susan and Pat. Susan, thank you for encouraging me with those supportive conversations and for sharing your doctoral experiences, as well. Pat, thank you for being a great friend, who is always just a phone call away and who eagerly listens to my daily gripes and demands of this doctoral journey. Last, but not least, I would like to thank my Uncle Cecil for his continued support and guidance through this journey. I always welcomed your encouraging conversations during our late-night phone calls.

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## Chapter 1: Introduction to the Study

The topic of this study was the relationship between patient satisfaction with nursing care and hospital Magnet designation as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS; Kutney-Lee et al., 2010; Stimpfel, Sloane, McHugh, & Aiken, 2016; Berkowitz, 2016) survey scores. Magnet designation is a nursing excellence award given to hospitals that have met criteria of exemplary professional nursing practice, structural empowerment, and transformational leadership (Chen, Koren, Munroe, & Yao, 2014; Lundmark & McClure, 2005; Miller & Anderson, 2007; Zhu, Dy, Wenzel, & Wu, 2018). Magnet designation of hospitals is nationally and internationally recognized and bestowed by the American Nurses Credentialing Center (ANCC; 2018, para.1). Designation is designed to measure excellence in nursing, nursing leadership, and quality of patient care (Burge, Cronin, Kramer, & Ober, 2003; Hairr, Salisbury, Johannsson, & Redfern-Vance, 2014; Kaplow & Reed, 2008; Lash & Munroe, 2005; McClure & Hinshaw, 2002).

Patient satisfaction is one of the indicators of nursing quality as identified by the American Nurses Association (ANA). Nurses are the only health care personnel who care for patients in hospitals 24 hours a day and 7 days a week; thus, it is reasonable to assume that nurses will crucially impact the patient's healthcare experience (Bolton et al., 2003). Furthermore, among all healthcare providers, nurses have the social and professional responsibility to evaluate the relationship between delivery of health care services and patient outcomes, particularly patient satisfaction (Duffy & Korniewicz, 2002; Johansson, Oleni, & Fridlund, 2002). As Ruland (1999) noted, the type of nursing care provided to

patients affected patient outcomes such as satisfaction. Current research has indicated that nurses' delivery of healthcare services is related to patient satisfaction, as measured by HCAHPS survey scores, and this relationship may be associated with Magnet designation (Kutney-Lee et al., 2015; Smith, 2014).

U.S. hospitals have relied heavily on HCAHPS scores to advertise, compete on, and compare healthcare products using indicators such as positive patient hospital experience, quality nursing care, and patient satisfaction (Saxton & Finkelstein, 2012). Some researchers have reported that nursing care is more reflective of HCAHPS scores than any other areas of the hospital experience (Kennedy, Craig, Wetsel, Reimels, & Wright, 2013) while other researchers have found that patient satisfaction developed from patients' preservice expectations, the perception of the care they received, and other cultural and environmental factors (Blank et al., 2014; Comley & Beard, 1998). Because of the increase in research that shows a link between Magnet designation and better outcomes for patients (Aiken, Havens, & Sloane 2000; Kutney-Lee, Stimpfel, Sloane, Cimiotti, Quinn, & Aiken, 2015; Smith, 2014) it was essential to study if patient satisfaction with specific nursing care is related to Magnet designation as measured by HCAHPS scores.

Patient experience data are provided by the HCAHPS survey and stored on the Hospital Compare database. This database shares patients' objective information by circulating hospital performance and quality of care using simple and understandable data from the patients' viewpoint (Hospital Compare, 2018). The HCAHPS standardized scores, though not explicit, allow the public to view metrics on patients experience and

satisfaction, which helps them to make informed choices (Mazurenko, Collum, Ferdinand, & Menachemi, 2017). In addition, HCAHPS survey scores can illustrate how well hospital staff performance is meeting patients' needs and identify areas for improvement (Frampton & Guastello, 2010). There is widely documented evidence in support of HCAHPS as a tool to measure hospitalized patient experience with health services (Kennedy et al., 2013; Kutney-Lee et al., 2009; Mazurenko & Menachemi, 2016; Tevis, Kennedy, & Kent, 2015). However, more documentation is needed to determine if patient satisfaction with nursing care as measured by hospital HCAHPS scores has a relationship to Magnet designation (Chen et al., 2014; Smith, 2014).

As a significant indicator of patient satisfaction, HCAHPS measures the patient experience of care. Measuring the patients' experience can provide a hospital with constructive information about outcomes such as the performance of nurses and revenue, and how the organization is viewed by staff and the public (Letourneau, 2016). Some researchers reported that HCAHPS scores are more reflective of nursing care than any other areas of the hospital experience (Kennedy et al., 2013; Otani, Hermann, & Kurz, 2010; Wolosin, Alaya, & Fulton, 2012). Other researchers have found that hospitals were more likely to receive higher HCAHPS scores when they also report high job satisfaction rates, high nurse-to-patient ratios, and positive work environments (Kutney-Lee et al., 2015; Manary, Boulding, Staelin, & Glickman, 2013; Smith, 2014).

Nurses are considered the most visible healthcare professionals and work more closely with patients than other providers (APPG on Global Health 2016, para 2 & 3; BMJ, 2017 para 3; Luna, 2018). Increasing nurses' knowledge of patient perceptions of



healthcare quality and patient satisfaction may allow the overall healthcare system to make necessary changes to address identified problems. Increasing nurses' knowledge can contribute, for instance, to the reduction of health care disparities and promote healthy choices in marginalized communities and the overall healthcare industry, according to researchers (Ritsema, Bingenheimer, Scholting, & Cawley, 2014; Wysong, & Driver, 2009). In investigations of health care over a 30-year time frame, researchers have documented increased improvement in the quality of nurse and patient outcomes in Magnet-designated hospitals compared to non-Magnet hospitals (Aiken, Smith, & Lake, 1994; Brady-Schwartz, 2005; Evans et al., 2014; McClure, Poulin, & Sovie, 1983). This evidence supports the need for leaders of non-Magnet hospitals to develop programs that imitate Magnet-designated hospitals. The development of these programs may ensure that patients seeking care at non-Magnet hospitals are given equal opportunity at service and care in spite of hospital status. Social change opportunities need not be costly as researchers have found that small adjustments in healthcare organizational culture and practice contribute to satisfied patient experience (Lee, Moriarty, Borgstrom, & Horwitz, 2010). Nursing actions and practices such as cultural competence, effective nursing communication, respect for patients, treating patients with dignity, and educating limited English proficiency (LEP) patients in a language of choice should be everyday occurrences (Appold, 2017; Dickerts & Kass, 2009; Karliner, 2016; Radtke, 2013; Sokol-Hessner, Folcarelli & Sands, 2016; Weech-Maldonado, Elliott, Pradhan, Schiller, Hall, & Hay, 2012a). Implementing these nursing practices does not need to be expensive as applying for Magnet designation. Inexpensive continuing nurse education and

reinforcement of basic common courtesy can greatly improve the patient experience (Harrison & Novak, 1988; Martin, Arenas-Montoya & Barnett, 2015; Meade, Bursell, & Ketelsen, 2006).

In this chapter, I introduce the study topic and provide the background, problem statement, and purpose of the study. In the chapter, I also provide the research questions and associated hypotheses and explore how the study's theoretical framework advances scientific nursing knowledge. In addition, the nature of the study is discussed, and definitions of key terms are provided. I also consider the assumptions, delimitations, limitations, and significance of the study. The chapter concludes with a summary of key points.

### **Background**

Boyer and Lutfey (2010) argued that over the past fifty years, the changing dynamics of the patient-caregiver experience is one of the most extraordinarily discussed health care policy and professional practice topics. The active role of the patient has become more acceptable, and hospitals are taking notice (Boyer & Lutfey, 2010). Hospitals and other healthcare institutions are now measuring the quality of care and patient satisfaction by evaluating the patients' experience (Berkowitz, 2016; Wolf, 2018).

Quality of care is measured against how the hospitalized patients evaluate their engagement with the nurses and physicians who care for them (Prey et al., 2014). For instance, caregivers such as Registered Nurses (RNs) spend proportionately more time with patients than any other healthcare professionals. Nurses are the most visible health care professionals, and events happening during the patient-nurse encounter will

influence the patients' reported experience and satisfaction (Aiken et al., 2011; Berkowitz, 2016; McHugh & Witkoski-Stimpfel, 2012; Wolf, 2018). Researchers, however, have reported that most nursing care duties are difficult to measure, and healthcare organizations often do not keep an adequate record of such activities (Berkowitz, 2016; Lucero, Lake, & Aiken 2009). Currently, due to the complex and competitive healthcare climate, hospitals are forced to measure and document nursing care activities. These actions allow hospitals to compete with each other and qualify for reimbursements set by the federal government (Dafny & Lee, 2016; Young, Burgess, Desai & Valley, 2002; Wishner, Solleveld, Rudowitz, Paradise, & Antonisse, 2016).

To evaluate the relationship between quality and outcomes, researchers have linked better patient results and lower mortality rates to quality work environments and decreased patient to nurse ratio in Magnet hospitals (JACHO, 2007; McHugh & Stimpfel, 2012; Sochalski, 2004; Stimpfel, Rosen, & McHugh, 2014). In contrast, other researchers have identified links between Magnet hospitals, higher HCAHPS scores, better patient, and nurse outcomes compared to non-Magnet hospitals (Aiken, Smith, & Lake, 1994; Chen et al., 2014; Kutney-Lee et al., 2015; Smith, 2014; Stimpfel et al., 2016). However, few researchers have explored whether there is a relationship between patient satisfaction explicitly linked to nursing care in hospitals with Magnet-designation and high HCAHPS scores (Lee et al., 2015; Lake, Germack, & Viscardi, 2015). This limited research leaves a gap in the literature, and as a result, I am attempting to address it. Therefore, my research will add to the current literature research and addresses whether hospital

Magnet-designation was related to patient satisfaction with specific nursing as indicated by HCAHPS survey scores.

This study was needed to lessen the gap in the literature and realize the extent to which nursing care contributes to patient satisfaction and subsequently increase HCAHPS scores among Magnet-designated and non-Magnet hospitals. There is evidence that patients' perceptions of specific areas of nursing care are related to Magnet-designation. Therefore, it will be the responsibility of healthcare leaders, experts, policymakers, and administrators to implement programs, policies and interventions to improve the care experience through standards similar to Magnet-designation programming without necessarily requiring hospitals to pursue the formal designation.

### **Problem Statement**

The problem for this study was that some healthcare organizations failed to identify nursing care activities as essential measures of the patient experience which impact patient satisfaction. Further, there was limited research as to whether patient satisfaction with nursing care is related to Magnet-designation as measured by HCAHPS scores. Additionally, many problems are impacting the United States healthcare system, and there are a variety of factors that have contributed to these problems. Some contributing factors included the growth of the population with chronic illnesses and the increased number of patients without health insurance. Similarly, increased use of technologies, including the related cost and changes in the delivery of health care, has also been identified as economic and situational factors (Bolton et al., 2003; Conklin, 2002; Funk, 2011; Pallin, Espinola, & Camargo, 2014; Preventive Services, 2014;

Rowland & Lyons, 1996). Equally important was the emergence of "The Patient Protection and Affordable Care Act (ACA)," which has signaled to hospitals that they need to adapt to new technologies and shift towards economic-based care (Rosenbaum, 2011; Health Resources and Service Administration (HRSA), 2012; Porter, 2009).

The federal government implemented the Value-Based Purchasing (VBP) program to reduce healthcare cost and improve patient care and outcome. VBP ties a percentage of hospital reimbursements to increased hospital HCAHPS scores (Berkowitz, 2016; Chee, Ryan, Wasfy, & Borden, 2016). Hospitals hoping to capitalize on federal payments have realized that satisfied and dissatisfied patients are reporting their experiences. The result of positive patient satisfaction experiences is reflected as higher hospital HCAHPS scores. These increased hospital HCAHPS scores are specifically related to quality nursing and nursing care which influence the whole patient experience (Berkowitz, 2016; Kennedy et al., 2013; Kutney-Lee et al., 2009; Manary et al., 2013; Wolosin, Ayala, & Fulton, 2012).

In today's healthcare market, improving patient satisfaction with nursing care as measured by hospital HCAHPS scores is essential to the economic survival of hospitals. Furthermore, hospitals must achieve high HCAHPS scores to maintain a competitive edge with consumers and to receive reimbursement premiums from government and private health insurance agencies (Babalola, 2017; Geiger, 2012; Levine, 2015; Riskind, Fossey, & Brill, 2011). Even though a low HCAHPS score does not eliminate reimbursement entirely, hospitals work to improve their scores to maintain a viable economic situation based on quality, which is rewarded with premium inducements,

though for delivery of the same quality care but different results (Aragon, Richardson, Lawrence, & Gesell, 2013; Berkowitz, 2016; Riskind et al., 2011).

One such competitive edge sought by hospitals is gaining Magnet-designation. Hospital Magnet-designation is a coveted award and is linked to nursing excellence and dedication to patient care quality. For example, Magnet-designated hospitals offer positive work environments for nurses and are promoted as best places for patients to receive care. Previously, however, the major emphasis of Magnet-designation research was based on hospital characteristics related to indicators, such as adequate nurse staffing, nurse retention rates, and job satisfaction (McClure, Poulin, Sovie, & Wandelt, 1983; Tai & Bame, 2017; Valentine, 2013; Vila, 2016).

Currently, there is limited research as to the relationship of hospital Magnet-designation to patient satisfaction and increased scores on HCAHPS as explicitly related to nursing care. Though many hospitals pursue Magnet-designation, this research limitation posed doubt as to whether it is worth the journey that the Magnet process entails (Trinkoff et al., 2010). Additionally, the limitation creates an opportunity to conduct more research to determine whether Magnet-designation improves patient satisfaction with specific nursing care as measured by increased HCAHPS scores. Further, there are many reasons hospitals may not seek Magnet designated status. Reasons such as indirect and direct ongoing economic costs associated with pursuing and maintaining Magnet status. Some researchers, however, explained that Magnet-designation demonstrates the organization recognized standards such as high quality of nursing (Aiken, Havens, & Sloane, 2009; Jayawardhana, Welton, & Lindrooth, 2014;

Wood, 2010). Magnet-designation also shows positive organizational culture and positive observational studies outcomes which strengthen the need for support of specific principles and create opportunities for further research (Aiken et al., 2009; Needleman & Hassmiller, 2009). Even though there is support for Magnet-designation, other studies have suggested it is unclear from evidence whether Magnet hospitals produce better outcomes or whether hospitals with better results were already performing at high standards (Barnes, Rearden, & McHugh, 2016).

As consumers, seekers of healthcare services have forced the healthcare system to change its usual ways of doing business. The healthcare system has shifted its focus from clinical outcomes such as morbidity and mortality, pressure sores, and falls to more experience-based outcomes such as patient satisfaction (Aiken et al., 2011; Choi & Boyle, 2013; Kalisch, Tschannen, & Lee, 2012; Morehead & Blain, 2014; Shekelle et al., 2013). Patient satisfaction has become one of the most important characteristics of nursing care quality (Smith, 2014; Sofaer & Firminger, 2005; Yellen, 2002). However, researchers have revealed there are disparities of care between centers of excellence, like Magnet, designated and non-Magnet hospitals (Missios & Bekelis, 2017).

Many hospitals strive for Magnet-designation through the Magnet Recognition Program as an endorsement of a favorable and approving organizational environment for patients and nurses (Havens & Aiken, 1999; Stimpfel et al., 2016). Research revealed that there is better nurse to nurse, and nurse to physician, interactions in Magnet-designated hospitals, and such attributes can contribute to improvement in patient satisfaction

(Manojlovich & DeCicco, 2007; Scott, Sochalski, & Aiken, 1999; Schmalenberg & Kramer, 2008; Upenieks, 2003; Witkoski-Stimpfel, Sloane, & McHugh, 2016).

Moreover, the Magnet-designation hospital model espoused an excellent work environment for nurses, and as a result many hospitals have positive rates of nurse and patient satisfaction (Goode, Blegen, Park, Vaughan, & Spetz, 2011; Kutney-Lee et al., 2015; McHugh & Ma, 2013; Stimpfel et al., 2016). However, cohesive agreement is lacking on the real influence of the Magnet-designation model on these outcomes (Salmond, Begley, Brennan, & Saimbert, 2009; Trinkoff et al., 2010).

As previously Trinkoff and colleagues (2010) conducted a study on nurses' work environment in Magnet-designated and non-Magnet hospitals; no relationship was found between Magnet status and work environment (e.g., overtime; physical demands). Interestingly, since these two types of research illustrated opposing results, there is further need for studies to explore connections between nurse practice environment and Magnet-designation with patient outcomes (Salmond et al., 2009).

Conversely, several researchers have documented evidence that there are differences in the work culture of Magnet designated and non-Magnet hospitals (Aiken et al., 2009; Lake & Friese, 2006; Trinkoff et al., 2010). On the other hand, some researchers argued that adequate nurse staffing and improved nurse work culture are associated with a decreased hospital mortality rate in most hospitals not necessarily related to Magnet-designation (Aiken et al., 2011). These inconsistencies prompted further studies in which McHugh et al. (2011) found overwhelming evidence that substantially supported the trend that Magnet-designated hospitals established better



work environment for nurses compared to non-Magnet hospitals. In support of Magnet-designation, the researcher concluded that better work environment resulted in higher job satisfaction and less burnout. Additionally, in a previous study, Aiken, Clarke, Sloane, Lake, and Cheney (2008) agreed that better work culture for nurses resulted in improved patient outcomes. In this 2008 study, the nurses' report of positive job experience and better care environment were associated with better quality care for patients' and lower risk of mortality.

On the other hand, Barnes, Rearden, and McHugh (2016) performed a study to determine whether Magnet-designated hospitals were linked to lower central line-associated bloodstream infection (CLABSI) rates. In their analysis of CLABSI rates, Barnes and colleagues compared 291 Magnet-designated hospitals to 1,074 non-Magnet hospitals. A beneficial relationship between Magnet-designation and CLABSI rates was found, even after matching on important hospital characteristics. Specifically, 54% of Magnet-designated hospitals had CLABSI rates lower than the national average compared to only 41% of non-Magnet hospitals. This research indicates hospitals following the policies and organizational cultures identified as Magnet demonstrate positive clinical outcomes.

Further, hospital Magnet-designation was a predictor of CLABSI rates before and after matching of hospital characteristics which showed Magnet hospitals had a markedly high probability of having better than average CLABSI rates (Barnes, Rearden, & McHugh, 2016). One limitation later acknowledged in this 2016 study was whether the Magnet hospitals in the study had a system of quality improvement to decrease CLABSI,

which could explain lower rates of infections; the researchers were not aware (Barnes, Rearden, & McHugh, 2016). This same study, however, warned that while Magnet-designation is linked consistently to high-quality nurse environments and better patient outcomes, the effects of designation on existing nursing care excellence require further research (Barnes et al., 2016).

A large body of evidence is available on the patient perceived quality of care and patient satisfaction (Jaipaul & Rosenthal, 2003; Kessler & Mylod, 2011; Mazurenko et al., 2017; Shah, Patel, Rumoro, Hohmann, & Fullam, 2015; Wolf, Miller, & Devine, 2003). With the advent of social media and other twenty-four-hour news outlet, consumers have gained the ability to compare the standards of health care delivery services through shared experiences and relationship declarations. These mutual experiences allow for communities to bind and validate each other (Hardin & Conley, 2001). Consistent use of devices by consumers to compare experiences have heightened the demands for healthcare agencies to improve healthcare quality.

Further, the healthcare system has seen the passage of ACA and Centers for Medicare and Medicare Services (CMS) which introduced financial penalties for poor patient outcomes and incentives with help from HCAHPS. Together, these health care agencies have persuaded hospitals and other health organizations to increase the quality of patient care, nurse outcomes, and nursing standards. Most hospitals are convinced that compliance with health regulations and participation programs enhance standards and improve competitive edge. These factors can benefit nursing practice and improve patient care delivery experience and increase patient population flow, thus improving the

hospital economic bottom line (Anderson et al., 2006; Brooks-Carthon, Kutney-Lee, Sloane, Cimiotti, & Aiken, 2011; Friedman & Basu, 2004; Hill, 2010).

Currently, patients' perceptions of health care quality and patient satisfaction are perhaps two of the most important factors in the healthcare delivery system (Jha, Orav, Zheng, & Epstein, 2008; Sofaer & Firminger, 2005; Wolf, 2012). Patients' satisfaction with hospital delivery services is a significant signal to nurses that their care has met patients' expectations. Further, CMS reimbursement is contingent upon quality measures such as patient satisfaction with nursing care as determined by HCAHPS scores. Hospitals are forced to participate in the patient satisfaction competition. Increasingly attention is unwittingly paid to public reports of patient hospital experience (Kutney-Lee et al., 2009). Stakeholders and patients as consumers examine hospital structural culture, such as nurse-physician communications (McFarland, Johnson-Shen, & Holcombe, 2017) and participation in value-based performance (McFarland, Ornstein, & Holcombe, 2015) and use the information to make choices.

In contrast, there is limited research that has explored the impact that Magnet-designation has on patient satisfaction with nursing care as related to HCAHPS scores (Goode et al., 2011; Salmond et al., 2009; Trinkoff et al., 2010); this study complements the current body of knowledge. My research sought to lessen the gap in the literature on how Magnet-designation of hospitals may affect patient HCAHPS scores relating to nursing care. Further, the study examined if and to what extent patient satisfaction is related to Magnet-designation. There is evidence that Magnet-designation is likely to affect a patient's perception of satisfaction with nursing care using the HCAHPS survey.

Thus, healthcare administrators should pursue efforts to implement policies and interventions intended to increase and ultimately remodel nursing care utilizing the Magnet-designation standards and process.

### **Purpose of the Study**

The purpose of this quantitative study was to determine whether hospital Magnet designation is linked to patient satisfaction with nursing care as reflected in HCAHPS scores. Specifically, I sought to explore the relationship between documented evidence of nursing care delivery and patients' perceptions of health care quality. To do so, I compared the performance of Magnet-designated hospitals to non-Magnet hospitals in terms of patient satisfaction as reflected in hospital HCAHPS scores. The independent variable was Magnet designation while patient satisfaction of nursing care was the dependent variable.

### **Research Questions and Hypotheses**

The research questions for this study addressed hospital Magnet designation and patient satisfaction with nursing care based on receiving effective nurse communication, receiving effective pain management, having responsive staff, receiving explanations of how to use medicine, receiving timely care, and being willing to recommend the hospital. The quantitative nature of the study also required the creation of testable hypotheses. The research questions and hypotheses are, as follows:

RQ1: Is there a relationship between Magnet designation and patient satisfaction with receiving effective communication?

$H_01$ : There is no relationship between Magnet designation and patient satisfaction with receiving effective communication.

$H_A1$ : There is a relationship between Magnet designation and patient satisfaction with receiving effective communication.

RQ2: Is there a relationship between Magnet designation and patient satisfaction with receiving effective pain management?

$H_02$ : There is no relationship between Magnet designation and patient satisfaction with receiving effective pain management.

$H_A2$ : There is a relationship between Magnet designation and patient satisfaction with receiving effective pain management.

RQ3: Is there a relationship between Magnet designation and patient satisfaction with receiving timely responsiveness of care?

$H_03$ : There is no relationship between Magnet designation and patient satisfaction with receiving timely responsiveness of care.

$H_A3$ : There is a relationship between Magnet designation and patient satisfaction with receiving timely responsiveness of care.

RQ4: Is there a relationship between Magnet designation and patient satisfaction with the explanation of medicine?

$H_04$ : There is no relationship between Magnet designation and patient satisfaction with the explanation of medicine.

$H_A4$ : There is a relationship between Magnet designation and patient satisfaction with the explanation of medicine.

RQ5: Is there a relationship between Magnet designation and patient willingness to recommend hospital?

*H<sub>05</sub>*: There is no relationship between Magnet designation and patient willingness to recommend the hospital.

*H<sub>A5</sub>*: There is a relationship between Magnet designation and patient willingness to recommend the hospital.

### **Theoretical Framework for the Study**

The theoretical framework for this study consisted of expectancy disconfirmation theory (EDT) and cultural health capital (CHC). These theories are based on patient satisfaction and dynamics of nursing care. There are numerous theories linked to satisfaction (customer, desire, atonement, and job). However, there are no collectively recognized theoretical models for patient satisfaction (Hudak, Hogg-Johnson, Bombardier, McKeever, & Wright, 2004). For this study, the expectancy-disconfirmation theory provided a framework to examine the healthcare encounter as it relates to patient satisfaction and determinants such as nursing care as measured by the hospital's HCAHPS survey. In conjunction, the cultural health capital theory was included to address organizational norms or structures that may exist differently in Magnet-designated versus non-Magnet hospital settings.

Several healthcare works of literature revealed gaps between the patient expectations and nurses' perception of nursing care. Almost every patient who seeks health care has expectations based on his or her knowledge of their illness (Buerhaus, Donelan, Ulrich, & Norman, 2007; Ferguson, Ward, Card, Sheppard, & McMurtry, 2013;

Oermann & Templin, 2000). Most patients regard nurses as the gate-keepers to the healthcare experience and as the healthcare professionals whom they trust most to tell them about their care (Berkowitz, 2016; Rutherford, 2014). Patients' expectations of care are associated with factors such as culture, age, race, socioeconomic status, or level of understanding about their disease process (Conroy, Feo, Bocout, Alderman, & Kitson, 2017; Davis & Smith, 2013; Hankerson, Suite, & Bailey, 2015; Sorkin, Ngo-Metzger, & De Alba, 2010; Troung, Paradies, & Priest, 2014a; 2014b; Weech-Maldonado, Hall, Bryant, Jenkins, & Elliott, 2012). Expectations are also influenced by a perceived idea. An idea of how care by the nurse should be performed or how the hospital setting is aesthetically laid out. According to expectations, the patient is inclined to compare the completed service to his or her perceived performance, then judge both the initially expected performance with the service received, which may result in satisfaction or dissatisfaction (Anderson & Hair, 1972; Johnson, Nader, & Fornell, 1996; Poister & Thomas, 2011).

Parasuraman, Zeithaml, and Berry (1985) theorized that the service quality researchers and consumer satisfaction researchers have differences in the way expectations are viewed. Parasuraman et al. proposed a model that clarified how service marketers explained the lack of understanding of consumers in a service experience. The lack of understandings is called 'gaps' and may affect how consumers perceive quality. One such difference described by Torpie (2014), who explained "healthcare is not like other businesses, and patients are unlike other kinds of customers" (p. 6). The author argued that in the traditional sense, patients are not customers and should not be

identified only by their clinical diagnosis. Additionally, Torpie revealed that marketing experts create expectations that hospitals purchase and then sell to customers as essential ingredients to a quality patient experience. Patients, the author postulated go to a hospital to receive safe and effective care in a clean environment and have nothing to compare their expectations to other than the marketing sold to them.

The expectancy theoretical framework for this study is based on patient satisfaction (i.e., if expectations are met) and patient expectation (i.e., what patients expect) with nursing care delivery in Magnet designated and non-Magnet hospitals. Literature research revealed that nursing care plays an essential role in the healthcare industry, and many nursing functions are used as quality care survey indicators to measure patient satisfaction or dissatisfaction.

Commonly, satisfaction is described as subjective and ambiguous and may arise from the consumer's own experiences and expectations with the product or service (Comley & Beard, 1998). Similarly, Singh (1990) viewed patient satisfaction as an attitude influenced by a patient's expectation, which is unpredictable and subject to change. On the other hand, some theorists saw patient satisfaction as an outcome of assessing the product or service performance for which expectations played a vital role (Abramowitz, Coté, & Berry, 1987; Taylor, 1994). Therefore, to operationalize the satisfaction process and explain patient satisfaction, the expectation-disconfirmation model is used in this study.



## **Expectancy Disconfirmation Theory**

The expectancy disconfirmation is used as the foremost marketing model to evaluate, predict, and explain satisfaction in marketing industry literature. Expectancy disconfirmation targets the gap between performance and expectations (Hudak et al., 2004; Van Ryzin, 2005). Oliver (1977) proposed EDT to evaluate the consumer postexposure satisfaction with products as a determinant of expectations, performance, and disconfirmation. Since then, Churchill and Surprenant (1982) and Oliver and DeSarbo (1988) studied expectancy disconfirmation, making it an important marketing and consumer satisfaction research model. For example, Lankton and McKnight (2009) proposed that EDT used expectations, disconfirmation, and performance to influence consumer satisfaction. Both authors explained that in information technology, satisfaction is an essential variable that exemplifies the user's mindset, reaction, and emotional state of the system which follows an experience.

Oliver (1977, 1980) described consumer satisfaction as a central part of the disconfirmation experience. The assumption is that consumers foster cognitive and emotional expectations of product purchase performance. In this process, consumers draw upon expectations, perception, and disconfirmation of the product performance based on their own experiences, from responses of others, or from other origin such as advertisements or by word of mouth (Martin, 2016). These behaviors are reactions to the discrepancy between expectations and performance.

Disconfirmation is described as a subjective assessment and classified as the discrepancy between an original consumer expectation and perceived performance (Fisk

& Young, 1985; Jiang, Klein, & Crampton, 2000; Kucukarslan & Nadkarni, 2008; Lankton & McKnight, 2012; Tse & Wilton, 1988). Further, the consumer expectation is confirmed when a product or service meets expectation. When a product is positively disconfirmed, the performance is better than expected, and when a product performs more poorly than expected, it is negatively disconfirmed (Churchill & Surprenant, 1982). The expectancy disconfirmation model consists of four constructs: 1) expectations, 2) performance (perceived), 3) satisfaction, and 4) disconfirmation. The literature on each stage of the four constructs is explained according to research relevance.

**Expectations.** Cardozo (1965) was one of the earliest researchers to explain the effects of disconfirmation on product assessments. Cardozo proposed that when expectations are built up before product use or performance, the result will be negative perceptions, and expectations are negatively disconfirmed (i.e., the product performed worse than expected). In this situation where change is contrary to the expectations, consumers rate the product lower than when performance expectations are confirmed (i.e., the product performed as expected). In addition, Cardozo indicated that a different outcome is called 'assimilation' or 'dissonance effect.' In assimilation or dissonance effect, if perceived performance is only slightly less than performance expected, discrepancy or inconsistency will occur, and observed performance will be adjusted upward to equal expectations. Similarly, Olshavsky and Miller (1972) explained the dissonance/assimilation effect as raising expectations before using the product which will result in high awareness of performance even though the product performance was not up to the standard set. This effect explains the notion that performance is a fundamental

predictor of satisfaction. Whipple and Thach (1988) described satisfaction as a positive or negative disconfirmation of expectations. In their study on tourism travel, the researchers talked about comparisons of expectations with before and after experiences. Expectations before product or service purchase are compared with after experiences. This comparison is usually flawed as many factors affect the performance which results in negative or positive disconfirmation (Hughes, 1991; Whipple & Thach, 1988). In support of Whipple and Thach, Pizam, Shapoval, and Ellis (2016) argued that an outcome or course of actions determines satisfaction.

Woodruff, Cadotte, and Jenkins (1983) asserted that expectations are used as points of reference from which consumers compare their experiences with products and services. Customers use the assimilation-contrast theory process; as it is difficult for them to judge product performance, expectations may control actions, and assimilation effects such as adjusting behavior may occur. Expectations are also used as personal standards to evaluate brand performances as consumers rate the time they invested, and the cost paid for products and services (Jacoby, 1976). In addition, expectations are described as the individual's subjective opinions of perceived performance linked to a product brand as having some desired attributes (Woodruff et al., 1983). Cadotte, Woodruff, and Jenkins (1987) and Oliver (1980) also argued that satisfaction is the resulting perceived difference between the initial expectation and disconfirmed expectation.

Tse and Wilton (1988) suggested that expectations differ among consumers according to personal preferences. In the service quality literature, expectations are

regarded as predictions. Consumers personalize expectations relating to the product use or service experience, as they often perceive a discrepancy with product performance as close to their expectation beliefs. The result of comparing expectations and service use leaves a gap that determines satisfaction. The process of comparing the variables of expectation and perception leads to negative or positive disconfirmation. If the consumers' assessment of the product is less than their expectation, consumers are negatively disconfirmed, resulting in dissatisfaction. If the consumers' assessment is better than expected, consumers are positively disconfirmed and thus satisfied (Westbrook & Reilly, 1983).

**Performance.** Some consumer satisfaction models postulate that consumers have constructed performance expectations (Johnson, Nader, & Farnell, 1996). For example, Anderson, (1973) and Oliver, (1994) viewed consumer satisfaction as the difference between perceived performance and consumer expectation (disconfirmation). In contrast, Fornell (1992) and Westbrook and Reilly (1983) perspective is that perceived performance and expectation have a positive impact on satisfaction. Another model from Johnson and Fornell (1991) viewed market expectation and perceived performance as the same. Parasuraman and colleagues (1985) summed up the performance of service as having a high chance of inconsistency from heterogeneity. Parasuraman and others (1985) explained that the quality and nature of service (nursing care, medical service) is different according to the consumer, deliverer of service, and time.

Hudak et al. (2004) explained that clinical outcomes and hindsight expectations can affect the relationship between patient outcome satisfaction and embodiment (body-

self unity). Hudak et al. (2004) examined satisfaction of treatment from 122 individuals who underwent hand surgery. The researchers tested seven hypotheses:

Hypothesis (1) Satisfaction will be higher for the better overall clinical outcome.

Hypothesis (2) Satisfaction will be high as long as there are favorable evaluations

for either the majority or most important attributes. Hypothesis (3) Satisfaction

will vary positively with the extent to which perceived outcome concurs with

preoperative predicted expectations. Hypothesis (4) The effect of expectations on

satisfaction will be strongest when expectations are disconfirmed; satisfaction will

be highest if 'better than expected' (positive disconfirmation), then 'as expected'

(simple confirmation), and finally 'worse than expected' (negative

disconfirmation). Hypothesis (5) Satisfaction will be highest for those with

positive psychologic states regardless of whether an outcome is good or poor.

Hypothesis (6) The effect of psychologic state will be strongest in individuals

with poor outcome. Hypothesis (7) The proportion of individuals who are

satisfied will be highest for those describing cultivated immediacy (harmony

between body and self) and lived body states and lowest for the object body state

(disunity between body and self). (Hudak et al., 2004, pp. 732-733)

Hudak and others (2004) used a unique approach and tested multiple theories.

These theories were primary to patient satisfaction with treatment outcomes, using soon

to be patients undergoing elective hand surgery. The first three hypotheses were

confirmed before surgery, while the latter four were determined after surgery while

exploring the degree to which hindsight affect patients' perceived expectations. First, the

study confirmed that satisfaction would be higher when the patient viewed the surgery as a success than when viewed critically. Second, the hypothesis confirmed patients would report high satisfaction when their primary need for surgery was met successfully (Hudak et al., 2004). The most good in this study demonstrated the effect of hindsight expectations, even though it is not clear how its role affect embodiment it provided support for expectancy disconfirmation theory (Hudak et al., 2004). Further, the study also confirmed that satisfaction differs positively, to the extent that perceived performance successfully fulfilled the patients' pre-operative predicted expectation need for surgery.

Yi (1993) suggested performance has direct and indirect effects on consumer satisfaction through disconfirmation. That is, when assessment of a product performance makes the product unambiguous. Yi (1990, 1993) further added that consumers determine satisfaction with a product by drawing comparisons between their expectations and product performance. For example, if the performance exceeds expectations, then satisfaction should increase. If performance is below expectation, then satisfaction should decrease.

**Satisfaction.** In explaining the relationship between disconfirmation theory and satisfaction, some researchers have suggested that consumer satisfaction is directly related to expectations and that they have a direct effect on the disconfirmation process (Swan & Trawick, 1981; Tse & Wilton, 1988). However, others have argued that the impact was not significant (Churchill & Surprenant, 1982; Oliver & Bearden, 1983). The expectancy disconfirmation model explains that consumers incubate satisfaction

judgments by assessing actual products and services. The core of the satisfaction process starts with comparing expectation of performance with the actual product or service performance. Nyer (1996) extended Yi's (1993) findings on performance ambiguity and explained that the function of satisfaction could be applied subjectively (i.e., emotions and consumer's need) and objectively (i.e., product and service features). Furthermore, Nyer (1996) explained that the ambiguity in perceived performance could influence expectations and increase satisfaction while decreasing the influence of perceived performance on satisfaction. Alternatively, uncertainty in expectations reduces satisfaction, while the impact of performance on satisfaction increased.

The idea that disconfirmation can only occur when consumers have prior expectations represents lack of depth within the expectation-disconfirmation theory. Linder-Pelz (1982) theorized patient satisfaction consist of fulfilment, discrepancy and equity. Linder-Pelz (1982) asserted that consumer satisfaction was oppositely related to expectation. For example, if a consumer encounters health care with low expectations, then satisfaction would be higher than expected. If the expectations during the encounter were high, then the satisfaction would be lower.

Wirtz and Matilla (2001) and Westbrook and Reilly (1983) argued that consumers demonstrated dissatisfaction with the features of products they were unaware of before consumption. Wirtz and Matilla (2001) described satisfaction as a significant result of the consumer marketing activity which affects consumers current behavior and future interaction with the brand in terms of purchasing, brand loyalty, and word-of-mouth reviews. Wirtz and Matilla (2001) argument was supported by Judge, Locke, Durham,

and Kluger (1998) and Judge and Klinger (2008) in their critical research analysis on job satisfaction /dissatisfaction. The researchers supported the argument by explaining that satisfaction/dissatisfaction is triggered by perceived expectations to a product or service as a result of comparisons made to the individual beliefs, values or desires. Meanwhile in an earlier argument, Locke (1969) concluded that when values and expectations are experimentally separated, it is often valuing that determine satisfaction. Parasumaran et al. (1985) proposed that satisfaction, according to the discrepancy model, exist when the consumer perception meets or exceeds the original expectations Further, Parasumaran et al. (1985) explained that the discrepancy model of consumer satisfaction was created from the social learning theory. The social learning theory contends that learning occurs through several behaviors such as observation and imitation (Bandura, 1986). An application of social learning theory is illustrated by social media in which people use products or services then write reviews, resulting in others that observe and imitate by reading, modelling and purchasing the product based on documented reviews (Bandura, 1986; Thyer & Myers, 2008).

Magnet-designated versus non-Magnet hospitals are service delivery organizations, and EDT is chosen to evaluate patient satisfaction with specific nursing care. In today's business industry health care is traded as a commodity. Freeman (2012) argued health care is a right and not a product and the language used by experts often drive the narrative. Despite the disagreements, healthcare marketing continues to be a commodity by hospitals and other healthcare agencies. Hospitals use the lure of patient satisfaction to exchange the skills of nursing and medical professionals. Patients are



targeted as consumers and purchase health services as such by seeking out the best by using consumer guides. The rationale for choosing this theory linked back to the concept that the four constructs of EDT (expectation, disconfirmation, performance, and satisfaction) influence each other and are significant to explain patient satisfaction with nursing care when marketed as quality in health care (Conway, 1997). All four constructs are essential to describe the relationship between patient satisfaction with specific nursing care and Magnet-designation. The expectancy disconfirmation satisfaction model originated from a combination of healthcare and consumer literature used to satisfy researchers and consumers concerned about medical services (Pascoe, 1983).

**Disconfirmation.** The disconfirmation model holds that satisfaction is based on expectation before the service is experienced. Disconfirmation occurs when a person function of expectations is not met by perceived performance of a product or service. Disconfirmation influences consumer satisfaction and is one of the most reliable predictors of satisfaction (Nyer, 1996).

### **Cultural Health Capital**

Additionally, I used cultural health capital to address organizational norms/structure that may exist differently in Magnet-designated versus non-Magnet hospital settings. Cultural health capital originated from research conducted by Bourdieu and was redefined in 2010 by Shim, an American sociologist. Shim (2010) defined cultural health capital (CHC) as “the repertoire of cultural skills, verbal and non-verbal competencies, attitudes and behaviors, and interactional styles, cultivated by patients and

clinicians alike, that, when deployed, may result in optimal healthcare relationships” (p. 1).

Bourdieu, a French anthropologist, and sociologist, research literature relating to the disadvantaged and underserved people of Algeria and France (Grenfell, 2009). From these studies, he framed 'Theory of Practice' according to how he saw the collectivized world (Lareau & Horvat, 1999). In earlier works, Bourdieu wrote about the concepts of field, capital, and habitus. In 'Outline of a Theory of Practice,' Bourdieu (1977) focused on the relationships between individuals and behaviors, the social world, and the impact of social interactions. Bourdieu set out to explain the dynamics of individual and group actions and what guided behavior.

Bourdieu's (1998) assumption was that general behavior of an individual does not explain the actions of their social groups (such as minorities). Expressions are derived from cultures, personal values, societal laws, and customs, and are multifaceted. Bourdieu further sought to clarify the concept of peoples' behavior and actions and argued that both were not necessarily based on scientific abstractions but were rooted in empirically-driven sociological approach. He integrated these concepts throughout his studies and helped to explain his theories and their functions in society.

**Health care environment.** Borrell-Carrió, Suchman, and Epstein (2004) explained how biopsychosocial model deals with the philosophy of disease and illness, focusing on how suffering, disease, and illness are affected by the way society functions. The biopsychosocial model is a practical and clinical care guide for clinicians. It helps the clinician to identify and understand the patient's subjective experience and how it is a

necessary component to reaching the right diagnosis, positive health outcomes, and delivering benevolent care. For instance, practicing intersubjective relations between clinician and patient allows the patient latitude to express fears while encouraging the clinician to see the human side of the patient as well as inquire about expectations.

Having a relationship in which patient and clinician communicate well with each other allows for patients' unlimited power of speech and supports an environment for equal representation (Borrell-Carrió et al., 2004). In a cross-sectional study, Hausmann, Jeong, Bost, and Ibrahim (2008) used a multivariable logistic model and examined several races from the Behavioral Risk Factor Surveillance System (BRFSS) "Reactions to Race" module. Their goal was to explore the relationship between patient's perceived racial bias and preventive health care utilization; the researchers surveyed 28,839 White American, Hispanic American, and African American participants. The researcher showed that perceived discrimination was substantially related to under-utilization of preventive care such as Prostate Specific Antigen test for men (PSA), mammography, colonoscopy or sigmoidoscopy, and routine blood test. For instance, African Americans reported perceived bias three times more often than non-minorities (10.9%), followed by Hispanic American (5.2%) and non-minorities 2% (White American). Further, perceived biases were more likely associated with poor health as self-reported by Hispanic Americans and African Americans (Hausmann et al., 2008).

Similarly, Lee, Ayers, and Kronenfeld (2009) used data from the 2001 Survey on Disparities in Quality of Health Care of 5,642 adults and examined the association between perceived provider bias, health care utilization, and health status among three

minority groups (African Americans, Hispanic Americans, and Asian Americans). The study showed that participants from these minority groups reported substantially more perceived provider bias and poorer health than non-minorities. According to Lee et al. (2009) the result of poor health is facilitated by perceived provider bias, which is related to the delayed use of health care services. The authors contended that besides causing physiological and psychological stress, perceived provider bias openly and meanderingly affects health care utilization and health status (Lee et al., 2009). Lee et al. (2009) used multiple questions related to healthcare services and provider attitude as a means to measure perceived provider bias. Although their research was on minorities' perceived provider bias, the researchers opted to include perceived bias on the lack of patients' ability to pay for service, language barrier, and gender because of the apparent globalization of discrimination (Lee et al., 2009).

**Stages of constructs in cultural health capital.** Cultural capital consists of three parts: incorporated, objectified, and institutionalized. Integrated cultural capital describes the personification of the individual, and represents cognitive abilities, individual knowledge, taste, and skills. Objectified cultural capital symbolizes quantifiable customs, social recognition, and representation of experience. Institutionalized cultural capital symbolizes formal education and recognizable educational achievements (Abel, 2008; Kamin, Kolar, & Steiner, 2013). Additionally, Bourdieu (1986) explained that all forms of capital are recognized as structures of social standards and principles in society and accepted as the way things are. For example, patients who are used to poor nursing care will be satisfied if they have never experienced better. For this section of the study, I will

use cultural health capital to explain organizational norms or structures that may exist differently in Magnet-designated and non- Magnet hospitals.

According to Kamin et al. (2013), the structural system explains that an individual's standing in society determines the kind of health resources available to him or her. Kamin et al. (2013) further revealed that people with better cultural and social resources behave better by practicing health prevention and demonstrating proper health care habits, whereas people with limited cultural and social resources often practice poor health habits and unhealthy behaviors. Cultural capital not only targets the individual's lifestyle and health behaviors, but it also affects the way the individual approaches the overall healthcare system. Limited cultural capital sets and creates an environment for healthcare experiences and permits the creation of social disparities in the patient-provider relationship (Jones, Trivedi, Ayanian, 2010).

**Expansion of cultural health capital.** Magnet-designation of hospitals is considered one of the most significant sources for measuring organizational excellence in nursing. Compared to non-Magnet hospital, Magnet-designated hospitals celebrate high levels of job satisfaction among nurses and less patient mortality (Aiken et al., 2009). Magnet hospitals also celebrate positive relationships between nursing leadership and professional practice. Currently, there are an estimated 5,564 registered hospitals in the United States. Of the total registered hospitals, 475 (8.8%) had Magnet designation as of February 2018 (American Hospital Association [AHA], 2018; Campaign for Action, 2017); the remaining 5,089 hospitals are non-Magnet.

In health care, cultural capital references the skills of communication and interactions among patients and clinicians. In my study, cultural health capital will relate to the power of the individuals to negotiate meaningful experiences that are important to improve quality of care and health outcome. Ubel, Scherr, and Fagerlin (2017), argued that cultural capital can be used or exchanged to empower the disadvantaged and marginalized patient in the health care relationship and may depend on the interactional skills of the caregiver and patient's expectations. It is important to note that illnesses can place minority, disadvantaged or marginalized individuals in different situations because of the complexity of the health care system. Also, at the individual level, factors such as employment, education and social behaviors may contribute to the different situations (Pellowski, Kalichman, Matthews, & Adler, 2013).

Minority patients are ranked high on the health and social determinants list. They have ailments that put them at risk for more diseases and adverse situations than their non-minority counterparts (Braveman & Barclay, 2009; Isaac & Schroeder, 2004; Jack, Jack, & Hayes, 2012; Thomas & Herren, 2008; Wright, 1990). According to Thomas and Herren (2008) with the Robert Wood Johnson Foundation, where people live, coupled with conditions inside and outside their homes can have significant health consequences. Factors such as social and economic structures associated with general health status, mental health, health behaviors, and chronic health problems put them at risk (Gaskin et al., 2008; Yen & Syme, 1999). Minorities are less likely to get preventive care, and they are more likely to suffer from deadly disorders such as certain kinds of cancers, heart

disease, and diabetes (Mead et al., 2008). Furthermore, when minorities do get sick, they are less likely to have access to quality care (ACP, 2010).

**Healthcare barriers and satisfaction.** Some researchers have suggested barriers to care for disadvantaged, or minority groups are linked to socioeconomic status and education and are significant predictors of health status and an individual's ability to get quality care. For instance, African Americans and Hispanic Americans are twice as likely to live in poverty (Mead et al., 2008) and are less likely to be as educated (van Ryn et al., 2011) than non-minorities and Asian Americans. Further, African Americans are more likely to be impacted by clinician racism during healthcare encounter than any other minorities (van Ryn et al., 2011). Harden (2000) contended that racial bias built from slavery is linked to persistent poverty, even with an abundance of public health and social interventions (Erwin, 2008; Byrd & Clayton, 2001). Bias continues to be associated with institutional racism (Watson, 2001), health behavior (Byrd & Clayton, 2001) and lack of cultural competence (Johnson et al., 2004). And despite the many studies on the causes of health disparities, there is limited consensus on how to resolve them (Mensah, 2005; Blendon et al., 2007; Chin, Walters, Cook, & Huang, 2007; Mullins, Blatt, Gbarayor, Yang, & Baquet, 2005).

Ethnic groups have long experienced problems with health insurance and access to health care. Researchers have shown that groups such as Hispanic Americans and African Americans are among the groups with the lowest insurance coverage compared to Caucasians or White Americans (Drewniak, Krones, & Wild, 2017; Javaid, Barker, Shahid, Jabeen, & Bailey, 2009; Komaromy et al., 1996; Yeager & Bauer-Wu, 2013). In

the rural South, researchers surveyed 3,694 minority and non-minority participants to examine how minorities experienced barriers when seeking health care services (Fowler-Brown, Ashkin, Corbie-Smith, Thaker, & Pathman, 2006). Fowler-Brown and associates (2006) investigated the potential relationship between perceived racial barriers and satisfaction with healthcare. Further, they were interested in whether this relationship was influenced by demographic. Of the group, 54% minority and 23% non-minority participants reported perceptions of bias in seeking care outside their communities. Thirty-six percent of participants agreed that they experienced racial barriers when seeking health care services in their communities (Fowler-Brown et al., 2006).

Younger, non-minority individuals who were uninsured and less educated were also more likely than other non-minorities to report perceived barriers. In contrast, African Americans perceived racial obstacles linked to the lower likelihood that they would be satisfied with care. Due to the history of racial barriers among African Americans in the South, the authors theorized that minority participants' perceptions could be linked to distrust and dissatisfaction with medical care (Fowler-Smith et al., 2006).

The perceptions of barriers to health care access and service consistently permeate minority groups (Cohen & Zammitti, 2017; Chen, Vargas-Bustamante, Mortensen, & Ortega, 2016; Thorpe, Thorpe, Kennelty, & Pandhi, 2011). Fowler-Brown and others suggested African Americans are more likely than White Americans to have felt disrespected during health care encounters on the basis of race. Further, other research has found communication between minority patients and care providers are often



incongruent. African Americans patients expressed concerns that care provider often dominated the conversation. Commanding roles of caregivers lead to lack of involvement on their part during communication. For Latino Americans, the perception is that the care providers are unable to speak their language and often interpreters or translators are not utilized during the encounter (Finke, Light, & Kitko, 2008; Fisher, Staiger, Bynum, & Gottlieb, 2007; Jackson & Garcia, 2014; Neese, 2015). Overall, minorities expressed that racial issues influenced care providers views and opinions of them in society as a whole. Meanwhile, because of the historical Tuskegee Syphilis Study by the government, African Americans revealed suspicions that their lives are not as valued as that of a White American by some healthcare institutions (Gamble, 1997; McCallum, Arekere, Green, Katz, & Rivers, 2006).

***Response to care access as a barrier.*** The healthcare system can act as a barrier to proper healthcare because of its structural makeup. The health care system, on paper, may appear organized it, however, it is fragmented and difficult to maneuver because of the multiplicity of healthcare programs (Enthoven, 2009). Health programs from federal, state, county or local organizations often do not coordinate care, and marginalized groups can find access to care difficult. Access to healthcare can link to financial and non-financial related barriers (Kullgren, McLaughlin, Mitra, & Armstrong, 2011). To understand individual's access to healthcare some researchers used Andersen behavioral model of health services. This model explains how the individual uses health services. It recognizes an individual use of health care services to be a function of three factors namely, demographics, health beliefs and personal characteristics. Individual

characteristics could be health insurance, family, income, illness, health status or community resources (Kullgren et al., 2011). Individual characteristics, demographics and health beliefs are significant in how expectations are formed and conceptualized into consumer satisfaction. The individual distinguishing characteristic role and status in society demands substantial responsibility in how the individual gauge expectations, (which are subjective, Singh, 1990). This perceived expectation is of future performance and evaluate the gap between expectation and performance which forms the satisfaction construct for service or product.

Even with access to care, minorities failed to get the care they need. In preventative medicine using core measures, 60% of minority individuals surveyed were unable to adhere to preventative tests such as mammogram, colonoscopy, or using maintenance medicine after a heart attack. On the other hand, Betancourt and Mania (2004) and Mensah (2005) identified bias within the healthcare setting as one of the main reasons for minorities to delay use of preventive care, leading to reduced health outcomes and health disparities. For example, researchers have found a substantial connection between perceived bias in the healthcare setting with depression, increased anxiety, and self-reported poorer health (Fiscella & Sanders, 2016; Lee, Fitzpatrick, & Baik, 2013).

***Lack of access, perceived bias and barrier to health care.*** Williams and Collins (1995) postulated social and institutional structures contribute to health inequalities. Institutional arrangements promote social segregation in business models with the use of laws, customs, and traditions (Jones, 1997; van Ryn & Fu, 2003). Further, Williams and Collins (1995) added that the consistent promotion of racist customs, laws, and traditions

that increased inequality in one kind of business tend to proliferate bias in another. According to Yearby (2011), the healthcare establishment is an example of such business model. Yearby (2011) wrote that hospitals are organizational structures of institutional and structural racism where persistent practices of health care bias continued, and though not new, have now been widely documented.

Jackson and Garcia (2014) and Kottke and Isham (2010) have documented evidence with recommendations on how to increase access to healthcare. The writers highlighted areas of barriers and suggested organizations must first identify the fundamental causes of the obstacles to access care appropriately. That is those causes that create barriers to access resources necessary to maintain health and avoid disease.

**Organizational structures and patient satisfaction.** Organizational structural barriers within the healthcare system are not different from the society at large. The healthcare system shaped according to the design of public and private leadership and the workforce follow the orders on how to perform the job presented. Betancourt, Green, Carrillo, and Ananeh-Firempong (2003), speaking from the organizational viewpoint, suggested that the availability and acceptability of health care for minority groups is the degree to which the nation's healthcare workforce and leadership composition mirrored in the general public. For example, about one third of the U.S. population identified as African American, Latino or Native American, but only represents 3% of medical school faculty, 16% of public health and 17% of city and county health officials. With evidence to support lack of diversity in health care organizational leadership and workforce, it is important to note that structural policies, procedures and care delivery will be limited in

its scope to adequately serve minority groups (Jackson & Garcia, 2014; Rodriquez, Campbell, Fogarty, & Williams, 2014).

Saha, Komaromy, Koepsell, and Bindman (1999) reported that persons from ethnic groups have lower healthcare utilization and are more unsatisfied with care. The researchers suggested racial differences among patient and physician may have contributed to the dissatisfaction. LaVeista, Nickerson and Bowie (2000) explored factors that affect outcomes of satisfaction with medical care using 1784 African American and White American cardiac patients. The study found African Americans were more likely to report dissatisfaction with care and distrust of staff. Improving the relationship between minority groups and the healthcare structure remains one of the most challenging efforts for nursing policy makers and practitioners and researchers as they explore ways to improve patient satisfaction and quality care. However, Morales, Elliott, Weech-Maldonado, Spritzer, and Hays (2001) suggested using “several different measures such as communication, access, and promptness is useful in identifying different facets of care that vary across patient populations” (p. 613).

Several studies concluded that lesbian, gay, transgender and bisexual older adults (LGBT) experience higher health care disparities compared to their heterosexual counterparts. As disclosure of sexual orientation is essential to health care, it is necessary for nurses and other medical professionals to approach LGBT patients without assuming everyone is heterosexual (Cannon, Shukla, & Vanderbilt, 2017; Choi & Meyer, 2016; Neville, 2006). Choi and Meyer (2016) added that it is critical from a service viewpoint

to have service personnel culturally educated on the needs of LGBT groups to reduce negative expectations of the healthcare experience.

In a previous study on education policy and research, Grenfell (2009) expressed the assumption that Bourdieu's use of the concept 'capital' is symbolic of capitalism and abundant economic resources. Grenfell noted that these power symbols are exercised in various societies globally. Bourdieu identified three kinds of capital that conceptualized an individual's social standing in society: economic (commercial or financial), cultural, and social capitals. Here, Bourdieu proposed that: 1) economic capital empowers the individual, 2) social capital identifies with personal assets and affords tangible benefits to holders of such assets, and 3) cultural capital exist within the familiarity of the dominant culture in a society (Sullivan, 2002).

My study focuses on the relationship between patient satisfaction with nursing care and Magnet-designation. Shim (2010) explained that cultural capital is situational and can be used to reflect different behaviors in social settings. Cultural capital provides theoretical context for the hypothesized relationship between the care of patients in Magnet-designated versus non-Magnet hospitals. In health care, cultural capital references the skills of communication and interactions. My study demonstrated how cultural power of the individual and cultural capital can be used or exchanged to empower the patient in the healthcare relationship. Hospitals as organizations with the use of surveys rely on patients based on their experiences to compare the service they expected and the service they received.

**Capital resources in healthcare.** Bourdieu (1977, 1986) linked effective communication of nonminority patients to social skills acquired from birth until death. Most non-minority patients are equipped with or assumed to have cultural capital. For example, capital begets capital. This means that if an individual has more economic, social or cultural capital he or she can use it to get more capital. Therefore, people with more cultural capital such as knowledge and ability to interact in stressful situations like health crisis will get more results (Patitsas, 2018).

Conversely, minority patients are sometimes determined by society to lack social and financial means to articulate necessities of cultural capital. Often, they are directed into paternalistic healthcare encounters that suppress their desire to exercise cultural health capital (CHC), and the ability to interact informatively. These kinds of relationship put minority patients at a disadvantage in the healthcare interaction process and further increased health disparities and social inequalities (Shim, 2010).

Inadequate health literacy, lack of health knowledge, and ineffective health communication are obstacles to negotiate health services. Unfortunately, healthcare illiteracy and other obstacles limit minorities power to be educated and access specialized providers and organizations for the care they need. (Alcaide & Castro, 2009; Georges, Bolton, & Bennett, 2004; Miller, Cage, Jackson, & Modlin, 2017; Osborn, Paasche-Orlow, Davis, & Wolf, 2007). While on the other hand, the research identified organizational culture and behaviors of health professionals as contributing factors to ineffective interactions and communications with minorities and the elders (Cho, Lee,

Arozullah, & Crittenden, 2008; Smith, Dixon, Trevena, Nutbeam, & McCaffery, 2009; Yeager & Bauer-Wu, 2013).

Cultural health capitals are resources that individuals may have acquired from different aspects of their cultural and social upbringing, and are tools needed to navigate social environment such as the healthcare system (Chase, 2011). The selected theory relates to the present study as it demands of the health professionals, policymakers, and researchers to treat each person with respect and dignity. The interactional approach allows the provider and patient to build mutual trust (cultural capital). Also, for health professionals to demonstrate culturally competent communication (shared values, practices of a group), and deliver quality care (Madden, 2015; Newman, Goulding, & Whitehead, 2013; Royal, 2012; Villalonga-Olives & Kawachi, 2017). Researchers have provided evidence of an incongruent relationship with minority patients and healthcare providers in which the minority patients rate interactions and interpersonal care as more harmful than White Americans reported (Arpey, Gaglioti, & Rosenbaum, 2017; Sorkin, Ngo-Metzger, & De Alba, 2010). Given the evidence that patient-nurse interpersonal relationship plays a vital role in the patient perception of satisfaction it is important to explore research for further contribution to the literature (Johnson et al., 2004). This contribution is essential to the delivery of healthcare and necessary to public health concerning bias and stereotyping among caregivers (Arpey, Gaglioti, & Rosenbaum, 2017; Penner et al., 2013; van Ryn & Fu, 2003).

Previous researchers have provided details on why culturally competent healthcare professionals are essential in today's health industry (Campinha-Bacote, 1995;

2002; Flowers, 2004). With the appropriate competencies and skills, nursing professionals might be able to make the patient's experience better regarding health outcome and satisfaction with care. In the cultural capital theoretical framework, several authors have explained that cultural and social capital is epitomized as status symbols in society (Lareau & Weininger, 2003; Shim, 2010; Williams & Durrance, 2008).

Pinxten and Lievens (2014) adopted Bourdieu method of social culture and illuminated how resources such as wealth and education distinguished racial and ethnic groups and legitimized status symbols that contributed to health disparities. As in previous examples, researchers have demonstrated how ethnic groups are especially disadvantaged because of the moral and social limitations that are often placed upon them in their everyday living (Chase, 2011; Dolezsar, McGrath, Herzig, & Miller, 2014; Epstein, Fiscella, Seller, & Strange, 2010).

Olsen (2003) claimed that the healthcare system is inherently relational, making most of the existing problems linked to behaviors and relationships. Further, the author cited that healthcare perspectives that determine traditional health policy offer limited and partial insights into human behavior and relationships. In contrast, other researchers have used Andersen Behavioral Model of Health Services to explain the contextual and individual determinants of health services and utilization (Ricketts & Goldsmith, 2005; Rust, Ye, Baltrus, Daniels, Adesunloye, & Fryer, 2008). Andersen (2008) categorized contextual and individual determinants the same way using three factors: 1) predisposing, 2) enabling and 3) suggesting or need. These characteristics described how the personal need to use the health services is determined. Predisposing explains the social and



cultural features existing before the illness. Enabling describes the individual family structure and health care organizational structure. Need describes the immediacy of the service. The immediacy of the need for care promotes the essential reason for health care services.

**Healthcare relationship and trust.** Evidence revealed, for minority groups predisposing characteristics such as ethnicity, cultural norms, trust and language play vital roles in the patient-provider relationship. Though the specific functions may not be apparent, some authors hypothesized that perceived racism influences cultural mistrust. Which often affects how the recipient observed satisfaction of care (Benkert, Peters, Clark, & Keves-Foster, 2006). Trust according to the Andersen Behavioral Model is a predisposing characteristic significantly linked to the use of health services (Hammond, Matthews, & Corbie-Smith, 2010). Although my research is not about trust, it is relevant to any healthcare relationship. Brockner and Siegel (1996) explained that confidence in others derives from expectations of their behaviors concerning one's future behavior. Further, these behaviors may not be acceptable and may produce negative results. Healthcare relationships are especially worthy of trust, as providers should be impartial to patient health concerns and benefits (Davies, 1999). However, relations between patient and provider are often unequal, with an appearance of involuntary trust.

Madden (2015) interviewed individuals from South Texas Mexican-American border communities regarding the popular misperception of being disadvantaged and lacking healthcare resources. These communities are often identified as marginalized and without proper healthcare access or government support for healthcare needs. By

integrating medical sociology and the critical race theory, Madden's (2015) found that these individuals manage healthcare exclusion by negotiating cultural capital (e.g., complementary medicine and remedies) from community-based outlets (e.g., community clinics, flea markets, and Mexican pharmacies). Trust is also an issue between border patrol and Mexican-Americans crossing into Mexico to buy prescription drugs. Marginalized communities often use the cultural capital to navigate their way out of being caught when they smuggle prescription drugs across the Mexican-American border. Low income and minority communities are often disadvantaged and lack the social and economic resources to access the things they need (Madden, 2015).

Dubbin, Chang, and Shim (2013) referenced patient care relationships and noted that patient and provider would bring diverse CHC to the care experience. From these distinct health capitals, provider and patient may find some factors of capital more useful and appreciated than others. Dubbin and colleagues examined features that provided analysis of cultural capital on how patients and providers used such capital to interact with each other, and how this interaction can build patient-centered care and relationship. Dubbin et al. (2013) explained that some patients cherish the clinical model of patient-centered care as it reveals a sense of uniqueness and personalization to the individual. Dubbin et al. (2013) examined the physician-patient relationship to determine the types of CHC exchanged in patient-provider interactions. The researchers set out to understand the processes by which CHC is acquired, developed and deployed and the impact (or lack thereof) of CHC on the content, tone, and outcome of interactions. Dubbin and others used the CHC framework to explore patients and providers' cultural resources, assets and

behavioral patterns and found that CHC works when patients can communicate psychosocial attributes that are recognized and used for health services.

In another study exploring CHC, Epstein and colleagues (2010) explained that patient-centered care is also directed by the value placed on the interactions between patients and providers. Further, Epstein et al. (2010) added that a patient-centered care model matters because it recognizes the intricacies of the human experience during the time of illnesses. It offers opportunities for patients to take part in their care and gives rise to the patient-provider relationship with shared understanding. Furthermore, it improves quality of lives and healthcare outcomes and brings attention to racial and socioeconomic disparities in health care (Bertakis & Azari, 2011; Epstein et al., 2010; Epstein & Street, 2011).

Sufficiency of cultural health capital can enable or also hinder communication during encounters between patients and providers. Communication is an essential vehicle for patient-clinician interactions. Dialogue must be rich in content, useful and congruent so that the recipient of information understands what is being said. Connection promotes adherence to care and produce a better patient outcome (Teutsch, 2003). Health capital is needed but is not sufficient to improve access to care or to eliminate poor health behaviors. Research from Kaiser Permanente in 2011 reported that even with the same access to care and network providers, people with more years of education seemingly do better with health than ones with fewer years (Robert Woods Johnson Foundation, 2014).

Chase (2011) provided an analysis of seventeen Hispanic/Puerto Rican women diagnosed with HIV/AIDS and explained how the existence of health capital enhances

patient power to bargain and interact with healthcare professionals. Meanwhile, the non-existence of health capital diminishes or disrupts the patient-provider relationship. In this study, the investigator examined women faced with challenges as they sought health care services for their HIV/AIDS diagnosis. Chase (2011) explained that the women were able to celebrate their successes while experiencing the ordeal of racial bias in healthcare and survived their illnesses. The emphasis of this study was to reveal patients' mistrust of healthcare systems, lack of access to care, health barriers, and health and racial bias. However, the author highlighted how the use of cultural capital and social capital helped these women to survive given their experiences with physical violence, health care disparities, and perceived biases. In this study, the cultural capital defined as a group of important resources individual acquired from families who raised them and socialized them into adulthood. Additionally, each cultural capital is designated as its habitus that differentiates participants' worldviews and preferences (Chase, 2011; Thompson, 2017). Chase (2011) divided the participants into three groups: women with expansive cultural and social capital, women with regular cultural and social capital, and women with less cultural and social capital. In contrast to women with more cultural capital, women with less cultural capital were weakened and had obstacles in their approaches to care for themselves. On the other hand, others were able to negotiate and improve their advantages and values during the patient-provider relationship.

The choice of this theory arose from its focus on factors that may alleviate health disparities specifically within the healthcare setting. The rationale for this theory allowed for research to explore the culture of organizations and the cognitive and behavioral

actions of individual administering care within these organizations. Overall, the method utilizes interactions and communications skills of clinicians and how their approach affects individual seeking healthcare services. Additionally, Shim's (2010) theory focused on health professionals, researchers, and policymakers who are in the position to decrease or eradicate disparities in healthcare service and quality (Kilbourne, Switzer, Hyman, Crowley-Matoka, & Fine, 2006). Some healthcare frameworks have focused on the public health (Gee & Payne-Sturges, 2004; Derose, Gresenz, & Ringel, 2011) and demographics (Harvey, Patel, Sandu, Wallington, & Hinds, 2014) and other attributes that contribute to disparities. However, the current study is based on the patient-nurse interaction and how patients perceive the interactions and quality of care received during the healthcare encounter. Further, these interactions may offer some explanations for several forces at work, leading to implicit behavior, poor communication and unequal treatment of individual from minority groups (Shim, 2010).

### **Nature of the Study**

The nature of this research relied on a quantitative design approach. The approach in this study provided numerical details related to the analysis of surveys to assess if the significant statistical relationship existed between two groups: Magnet-designated and non-Magnet hospitals. A quantitative design can be used in studies involving events that have already occurred, and data already collected. Data for this study, HCAHPS scores and Magnet-designated hospitals were received from secondary data and retrievable in publicly available databases (Hospital Compare; ANCC, 2015).

In this study, secondary data was collected from national public databases of Hospital Compare, American Hospital Association (AHA), and ANCC. Compared to collection of primary data, utilization of secondary data can be a cost-effective and expedient research method (Terris, Litaker, & Koroukian, 2007). Further, this quantitative study answered questions such as "what is" or "what are" to address relationships between variables (Creswell, 2014). A quantitative design allows for the demonstration of associations and relationships between variables. This study used secondary data in the research analysis and explore relationships between patient satisfaction with specific nursing care based on HCAHPS survey scores from Magnet-designated and non-Magnet hospitals.

The target population for this study consisted of patients from Magnet-designated and non-Magnet hospitals located in all 50 states in the United States. Only acute care hospitals were eligible for this sample. All hospitals in the sample met the criteria of providing acute care and exclusion of non-specialty hospitals, as listed on the databases. Non-Magnet hospitals are listed on the Hospital Compare and were randomly chosen. Magnet-designated hospitals were conveniently listed on the ANCC database and were selected according to criteria such as non-specialty, adult only, and location in the United States. Only hospitals with 300 or more responses from the HCAHPS survey for the 2015-2016 period were eligible for the sample pool. The sample for non-Magnet hospitals was established through stratified random sampling to prevent bias.

All Magnet-designated acute care hospitals were included in the sample. Also included in the sample was a stratified random sample of non-Magnet hospitals matching

the same number of Magnet-designated hospitals within the same state (bordering state when necessary). Each non-Magnet hospital that matched the inclusion criteria with 300 or more HCAHPS responses had an equal chance of being selected in the sample. The use of random sampling is to guard against bias in the sampling process. A random sampling table was created with a sample list of non-Magnet hospitals. The ANCC guidelines determined hospital Magnet-designation. Magnet-designation is listed on a public database and can be accessed by the public with additional viewing for paid members. Date of Magnet initial designation and dates/years of re-certification was also listed if applicable.

### **Definitions**

The following terms and definitions are used in this study:

*Agency for Healthcare Research and Quality (AHRQ)*: The AHRQ is a federal agency which is the health services research arm of the U.S. Department of Health and Human Services. It specializes in significant areas of health care research, such as quality improvement, outcomes, and effectiveness of care clinical practice; healthcare organizations; primary (preventive) care; and healthcare cost (AHRQ, 2016). The federal agency is the prime “source of funding and scientific assistance for health services research and research training for leading universities and other institutions” (AHRQ, 2016, para. 2). AHRQ partners with the public and private sector to build a knowledge base for what works and what does not work and then translates this knowledge into everyday practice and policymaking (AHRQ, 2016).

*American Nurses Credentialing Center (ANCC):* The “ANCC is the world’s largest and most prestigious nurse credentialing center (ANCC, 2016, para. 11). It is a subsidiary of the ANA and is responsible for promoting excellence in nursing and healthcare globally by using programs with mandatory criteria (ANCC, 2016). Hospitals on the credentialing center website have met ANCC criteria for Magnet designation. The year they were designated and contact information are listed (ANCC, 2017).

*Centers for Medicare and Medicaid Services (CMS):* CMS is a federal government agency within the United States Department of Health and Human Services. The agency provides healthcare coverage and funding through structured program eligibility (CMS, 2015).

*Expectations:* In the service quality industry literature, expectations are defined as consumers’ beliefs about what providers offer (Parasuraman, Zeithaml, & Berry, 1994). In nursing service, expectation has three components: (a) service potential (e.g., nurse licensure), (b) service process (e.g., waiting time for pain medication/assistance), and (c) service result (e.g., patient satisfaction; Blank et al., 2014; Hall & Press, 1996).

*Medicare:* President Lyndon Johnson signed the Social Security Act, commonly known as Medicare, into law on July 30, 1965. Medicare took effect in 1966, with 19 million persons signing up during its first year (Anderson, 2018). Medicare now covers 49.5 million Americans (Anderson, 2018). In addition to being federal health insurance for older adults (i.e., those aged 65 and older) and disabled persons of any age, Medicare covers younger people with permanent disabilities and other qualifying illnesses such as end stage renal disease and amyotrophic lateral sclerosis (Anderson, 2018). Medicare is



divided into parts ranging from A to D and is assigned according to specific services. It is funded through the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund, and the Health Care Financing Administration is responsible for overseeing the program (Anderson, 2016; Feuerman & Dale, 2012; Rajaram & Bilimoria, 2015).

*Medicaid:* Medicaid, a federal and state program, helps some people with limited income and resources with their medical costs. People such as pregnant women, older adults, and people with disabilities are eligible (Salganicoff, Ranji, & Sobel, 2015). Each state has different eligibility rules about applying for Medicaid as the state's participation is voluntary (Salganicoff et al., 2015). Medicaid also grants benefits to people not usually covered by Medicare, such as those utilizing nursing home care and personal services (Paradise, Lyons, & Rowland, 2015).

*Magnet-designated hospital:* Magnet designation is awarded to hospitals that meet all criteria set by ANCC in addition to undergoing the designation site survey. The site survey shows that the hospital has accomplished the full accreditation cycle and is thus permitted to use the Magnet designation (ANCC, 2016). A Magnet hospital is recognized as one that features nurse excellence, professional practice, and quality patient care (ANCC, 2016).

*Nursing care:* The context of nursing care is multidimensional, encompassing the values of the nurse and the patient, the nurse-patient relationship, financial factors, and the health care environment (Noureddine, 2001).

*Nursing*: There is no single definition of nursing. For this study, nursing was defined according to theorist Imogene King's definition. According to King (1981), nursing is a process of actions, interactions, and reactions as nurses and patients share information about their perceptions during and after the health care situation.

*Nurse/Registered nurse (RN)*: Registered nurses are individuals with educational preparation that enables them to sit for a state licensure nursing examination. Upon passing this examination, a nurse is state licensed under the state's administrative agencies which oversee the board of nursing. The nursing board's job is to keep the public safe and ensure that nurses are safe and skilled practitioners (National Council of State Boards of Nursing, n.d). A nurse is a highly skilled healthcare professional who applies technical knowledge and practical skills developed through education and career practice to care for patients (ANA, 2016). In their professional role, nurses transcend social and personal barriers to deliver care without judgment while preserving patients' dignity (Crossan & Matthew, 2013).

*Patient satisfaction*: This is the patient's subjective assessment and evaluation of the behavior, attitude, and care received from healthcare professionals (Singh, 1989).

### **Assumptions**

Assumptions are common factors that may influence a study and are out of the researcher's control. Hathaway (1995) explained that researchers make decisions to use a qualitative or quantitative approach although much thought is not given to the assumptions as to why they do. Moreover, researchers make assumptions relating to knowledge, reality and process of acquiring knowledge. These are relevant factors and

taken away; the study could be rendered irrelevant (Hathaway, 1995). Meanwhile, Guba and Lincoln (1985) explained that when researchers are set to do a project, they should identify an approach such as a quantitative, qualitative or mixed method. Choice of a strategy is influenced by circumstances affecting the researcher, research problem, issues being studied, or readers of the researcher's work (Guba & Lincoln, 1985).

The central assumption of my study was that a quantitative approach would be used. Available data from the ANCC, AHA, and Hospital Compare databases were complete and accurate according to the patient and organizational guidelines and characteristics. As the federal agency responsible for healthcare research and quality, the AHRQ conducted comprehensive quality checks on data and confirmed the validity of dependability, reliability, and consistency based on the agency's standards (AHRQ, 2016). My main assumption was to better understand if there was a relationship between patient satisfaction with specific nursing care and Magnet designation as indicated by HCAHPS scores. These assumptions were necessary for the context of this study, as data used are publicly available and must be viewed as truthful and without bias.

### **Scope and Delimitations**

This study is a quantitative non-experimental project, using patients' hospital experiences as indicated on HCAHPS scores. The scope of this study concentrated on exploring how patients perceived their experiences with nursing care in health services and the role hospital Magnet-designation played in those patient experiences.

Delimitations are factors that limit or place boundaries on the scope of a study and are in the researcher's control (Patton, 2002; Simon & Goes, 2013). The ANCC recognizes

hospitals nationally and internationally. One of the delimitations of this study is that hospitals outside the United States were excluded from my data sources. Specialty hospitals and others such as pediatric, psychiatric, and long-term care hospitals were also excluded from my data collection. These hospitals were not required to report HCAHPS data, however after my data collection HCAHPS is re-examining some specialty to be included in its survey process. Thus, they would not be suitable for this study (Press Ganey, 2015). Hospitals without Magnet-designation as of March 2015 were excluded from the study given the inclusion criteria that bound Magnet-designation between April 1<sup>st</sup>, 2015 to March 31<sup>st</sup>, 2016. Besides, results of the research are not generalized to hospitals outside of the United States or to described U.S.-based specialty hospitals. Variables are also considered delimitations and were chosen by me. The variables are a hospital's Magnet-designation, non-Magnet hospitals and target and patient satisfaction relating specifically to such items as effective nurse communication, pain management, timely responsiveness of staff, explanation of medicines, and willingness to recommend the hospital.

### **Limitations**

Secondary data collection might have been a limitation of this study as there could be potential issues with the HCAHPS survey. Specifically, issues related to the HCAHPS questionnaire data such as:

- Ethical issues such as compilation, storage, confidentiality and security (Mark, Eyssell, & Campbell, 1999; Wasserman, 2013).
- Gaps in data collection (Johnston, 2014)

- The integrity of the interviewer [hospital survey vendor requirements and translation and quality assurance guidelines] (Johnston, 2014; Research Brief, 2008).

Hospital culture and environmental design may affect patient satisfaction and eagerness to complete the survey and enthusiasm to respond honestly according to the hospital setting or interviewer's approach (McFarland, Ornstein, & Holcombe, 2015). Biases such as patient culture, population demographics, and the interviewer's actions could have affected patient responses and ultimately HCAHPS scores. The physical or social differences in nurses, in a caregiver's role, could have also influence patient perception of care, and thus change standardized survey responses (Morrison & Korol, 2014).

### **Significance**

Patient satisfaction is now linked to hospital reimbursement as a measure of nursing care quality, as established by HCAHPS survey scores. Quality care is now linked to Magnet-designation of hospitals. Whether Magnet-designation played a role in patients' response to questions related to nursing care and higher HCAHPS scores was the significance of this study. It is important that hospitals maintain acceptable higher patient satisfaction scores on HCAHPS surveys pertaining to nursing care. Increase HCAHPS scores allow them to receive full reimbursement for the services rendered, and also recognition from accrediting agencies and prospective patients. If patients are afforded the best clinical experience when they seek care, it can create potential positive impact within the health care industry. Further, studies have shown that patients' perceptions of

quality care are often determined by the quality of their healthcare experiences such as interactions and communication with nurses and other staff (Clark, 2004; Wanzer, Booth-Butterfield, & Gruber, 2004).

Reports of patient satisfaction and patients' perception of quality healthcare are significant to the hospital comparison and HCAHPS survey results. Patients' HCAHPS survey results are publicly reported to provide hospital performance information based on patient perception of overall care. It further gives hospitals understanding of patients' perception of nursing care, such as treating the patient with courtesy and respect, getting help from the nurse, pain treatment and communication in congruent language. It further assesses patient satisfaction and provides prospective patients with useful information on choosing a hospital based on patient's preferences. Hospital loyalty and economic gains are optimized when consumers are satisfied with their care (Huerta, Harle, Ford, Diana, & Menachemi, 2016; Lang, 2012; Richter & Muhlestein, 2017; Siminoff, 2013). Therefore, the potential implications for social change bounded by the scope of my study is focused on empowerment of nurses and patients, the role of patient satisfaction, HCAHPS and hospital leaders active and sustained contribution.

Nursing care is individualized, and patient satisfaction is subjective. Patients often confuse functions of hospital staff as responsibilities of nursing care which can impact satisfaction. To understand the nature of patient perception of care, it is important to explore patient satisfaction. To examine specific nursing care and use CHC framework with expectancy disconfirmation model. The EDT and CHC models described patient performance expectations and explained relationships with nursing care and patient

satisfaction (Lang, 2012; Rivers & Glover, 2008). Patient satisfaction is not merely about patient perception and nursing skills. It is influenced by where the care is delivered, who delivered care, and how the skills are performed. Performance expectations related to patient satisfaction are not a fabrication of performance, which are explained by hospital and nursing performances. Hospitals develop performance standards and set expectations for staff and through advertisement and other media engine set patient's expectations (LaVela & Gallan, 2014).

In this quantitative study, I investigated if there were relationships between Magnet-designation and patient satisfaction with specific nursing care based on results of HCAHPS survey scores (See Appendix A for HCAHPS survey). The healthcare industry in the United States has had varied successes in hospital patient outcomes and has shifted from clinical type outcomes to experience type outcomes and is searching for the role of quality care (Isaac, Zaslavsky, Cleary, & Landon, 2010; Schohalski, 2004). Measures of patient experience are accepted as the central part of healthcare quality, and hospitals are encouraged to improve clinical performances for better outcomes.

Hospital Magnet-designation demonstrates a hospital quality of nursing excellence and that the nurses have met the standards set (McHugh et al., 2012; Stimpfel et al., 2014, 2016). Researchers have continued to work fervently to relate quality care and nursing care to patient satisfaction and evidence has shown positive results (Berkowitz, 2016; Kutney-Lee et al., 2009; Manary et al., 2013; Otani et al., 2009, 2010). Patient satisfaction is now measured through HCAHPS report cards linking scores to healthcare reimbursements and bonus payments from CMS and private payers (Jaipaul &

Rosenthal, 2003). Quality of care is one aspect of the score linking expectation and satisfaction.

Since 2006, CMS implemented HCAHPS to measure patient experience with healthcare services. The majority of the HCAHPS questionnaires are linked to nursing care or services that are delivered by nurses and personnel supervised by nurses. Nurses are recognized as the core body of healthcare professionals and they have the most time intensive relationships with patients than any other healthcare groups. Nurses are educationally and emotionally prepared to develop therapeutic relationships with their patients through caring and nurturing behaviors (Pullen & Mathias, 2010). Additionally, verbal and non-verbal communication is significant to the delivery of quality care; however, patients' perception of quality may differ from the person delivering the care (Isaac et al., 2010; Jha et al., 2008; Spencer, Day, & Karia, 2014). Patients' perception of quality care may be reflected in their HCAHPS survey scores that are publicly reported on the Hospital Compare website. Hospital Compare allows prospective patients to compare hospitals according to past patients' experiences. In addition, HCAHPS scores are linked to CMS reimbursement, and hospitals are enticed with economic incentives. For example, hospitals may sustain reimbursement penalty if survey scores are not met, but they may also receive a bonus premium for fulfilling objectives. Otherwise, there would be no motivation to take part in the survey. There are six HCAHPS domains linked to nursing practice that contribute highly to patient satisfaction, including nurse communication, communication about medication, the responsiveness of staff, pain control, cleanliness and quietness of the environment, and discharge information.



## Summary

Magnet-designation is awarded to hospitals that demonstrate nurse excellence, positive work environment, and promote quality care (Messmer & Turkel, 2010; Patrician, 2013; Stimpfel et al., 2016). An assessment of quality care must take into account patient satisfaction (Kalisch et al., 2012; Stimpfel et al., 2015). Further, research is limited on the impact of hospital Magnet designation status on patient satisfaction. Chapter 2 reviewed the literature and discuss whether a significant relationship existed between Magnet-designation and non-Magnet hospitals. This is based on higher scores on HCAHPS related to patient satisfaction with nursing care. Studies revealed that patients' experience in Magnet-designated hospitals is better than non-Magnet. Other literature also found non-Magnet hospitals that give exemplary patient care resulting in satisfied patients. However, there are conflicts as to the contributing factors associated with this comparison (Lang et al., 2013; McFarland et al., 2015; Stimpfel et al., 2016).

## Chapter 2: Literature Review

### **Introduction**

The problem addressed in this study was the failure of some healthcare organizations in the United States to identify and promote nursing care activities as important aspects of the patient satisfaction with their experience. Hospitals have a growing concern with patient satisfaction as patients have become more informed about general healthcare issues, hospital and care quality, and various options to purchase healthcare (Anthony, Kloos, Beam, & Vidal, 2018; Gupta & Rokade, 2016; Hodnett, 2002; Jha, 2017; Prakash, 2010; Price et al., 2014; Sofaer, Crofton, Goldstein, Hoy, & Crabb, 2005; Tsai, Orav, & Jha, 2015). In addition, patient satisfaction has become vital to the financial survival of the healthcare industry.

Today, the advancement of technology presents different challenges for patient satisfaction. Many patients have become better informed about the overall function of the healthcare industry and understand the role technology plays. For example, healthcare businesses use technology to improve patients' lives and outcomes (e.g., by decreasing hospital stays). Specifically, for individual care providers, technology has become a tool to manage patient satisfaction, improve the healthcare experience, and measure quality of care (Kahn, Iannuzzi, Stassen, Bankey, & Gestring, 2015; Kutney-Lee et al., 2009). Programs like Magnet designation incentivizes hospital to implement and standardize technology in the care process (Lippincotts, Foronda, Zdanowicz, McCabe, Ambrosia, & 2017).

The purpose of my study was to explore the relationship between patient satisfaction with nursing care and Magnet designation. Specifically, I examined the relationships between Magnet designation and patient satisfaction with nursing care based on effective communication, effective pain management, timely responsiveness, explanation of medication, and willingness to recommend the hospital (Aiken et al., 2009; Andersen, 2008; Kutney-Lee et al., 2016; McHugh et al., 2013; Stimpfel et al., 2016). After Magnet-designated hospital classification, I used data from the HCAHPS survey (Hospital Compare, 2015) to analyze, measure, and compare patient satisfaction scores in relation to nursing care. The HCAHPS survey is used to compare patient hospital experience to help assess and evaluate care; additionally, HCAHPS aims to improve quality of care with the intent to promote patient satisfaction (Kutney-Lee et al., 2009; Manary et al., 2013; Otani et al., 2010).

### **Relevance of the Problem**

Researchers are increasingly using comparison measures such as surveys and questionnaires to evaluate the hospitalized patient care experience (LaVela & Gallan, 2014). Hospitals and governmental agencies -- private and public entities -- are assessing the patient's experience of clinical care based on the patient's perspective (Beattie, Murphy, Atherton, & Lauder, 2015; Manary et al., 2013; Tevis et al., 2015). Most healthcare systems utilize the publicly reported HCAHPS to measure how inpatients distinguish their hospital experience in order to understand patient satisfaction (Ervin, 2006; LaVela & Gallan, 2014). The development and implementation of the HCAHPS patient satisfaction survey by CMS has made patients' perspectives of their care

experiences publicly available. Participation in HCAHPS is voluntary for non-federally funded hospitals, but mandatory for hospitals that participate in federally funded health care programs such as Medicare and Medicaid (HCAHPS, 2015).

For several decades, researchers have linked quality care for patients to the care specifically delivered by nurses. However, hospitals were reluctant to give priority to nursing care until research literature connected quality nursing to outcomes including positive patient satisfaction and more favorable financial reimbursements from government and private healthcare insurers (CMS, 2006; Welton, 2006; Welton & Halloran, 2005). Previous researchers often suggested that factors such as quality nursing, adequate nurse staffing, appropriate work environment, and educational recognition promoted increased patient satisfaction (Ellenbecker, 2010; Goldstein, Elliott, Lehrman, Hambarsoomian, & Giordano, 2010; Kutney-Lee et al., 2009; McHugh & Chenjuan, 2014; Tanner, Gubrud-Howe, & Shores, 2008).

Some researchers have also found significant links between Magnet designation and patient satisfaction (Aiken et al., 1994; Chen et al., 2014; Smith 2014). Other researchers established connections between Magnet-designation and quality care (Evans et al., 2014; Stimpfel et al., 2016) as well as with increased nurse satisfaction (Aiken, Lake, Sochalski, & Sloane, 1997; McHugh et al., 2011; Stimpfel et al., 2016). Similarly, links between Magnet-designated hospitals and higher HCAHPS scores have been identified (Chen et al., 2014; Kutney-Lee et al., 2009; Smith, 2014). However, studies examining the relationships between patient satisfaction, nursing care, HCAHPS scores,

and Magnet designation are limited in quantity and recency (Chen et al., 2014).

Therefore, I undertook this study to lessen this gap in the literature.

This chapter includes a review of relevant and current literature on the relationship between patient satisfaction, as measured using HCAHPS scores, and hospital Magnet designation. The literature review includes discussion of Magnet designation, non-Magnet hospitals, patient satisfaction, and patient experience, among other topics relating to the research subject. I obtained literature from databases. In addition, I consulted websites with information on hospital Magnet-designation criteria and guidelines, and hospital survey reporting such as ANCC, Hospital Compare, and AHA, 2016. The chapter begins with an overview of my literature search strategy.

Additionally, this chapter includes discussion of the theoretical framework as it relates to the study variables, patient satisfaction and Magnet designation (Kennedy et al., 2013; Kutney-Lee et al., 2009; Stimpfel et al., 2014). I explain the development and progression of the Magnet-designation/Recognition Program and how it has affected nursing and patient satisfaction. I also describe the HCAHPS survey origination and its relationship to nursing care and patient satisfaction. In the literature review that follows, I first discuss Magnet designation of hospitals under the auspices of the Magnet Recognition Program. In the next section, I review current literature relating to the influence Magnet designation has on clinical outcomes, nurse staffing and education, and patient satisfaction, respectively. The literature review includes discussions and examination of the HCAHPS as a patient satisfaction tool. Last, I review current research on the concept of patient satisfaction, expectations, and perception of care.

### **Literature Search Strategy**

I used Walden University Library's research databases to locate most of the literature reviewed in the chapter. I obtained articles on a wide range of subjects such as nursing, health and social sciences, and policy administration and law. Specifically, I used electronic databases such as CINAHL, Medline, Cochrane, ScienceDirect, PsycINFO, PubMed, ProQuest, and Google Scholar. Other search strategies were used to find search terms addressing patient perceptions of satisfaction and Magnet-designation status in order to cast a wider net given that the literature results were limited. I found few scholarly articles specifically exploring patient satisfaction with nursing care based on the HCAHPS survey and Magnet-designation status. Through discussion with the Walden University librarian consultant, I decided to use specific search phrases and words (see the next paragraph) to find literature in this area. Regarding the study's theoretical framework, there is a large body of literature on the application of disconfirmation theory to consumer satisfaction for products and services (Fisk & Young, 1985; Lankton & Young, 2012; Tse & Wilton, 1988; Westbrook & Reilly, 19983). There are fewer studies on the application of the theory to healthcare, based on my review of the literature. Although the use of disconfirmation theory applied to healthcare has been limited in the past, the use of this theory for health satisfaction is on the rise (Hudak et al., 2004; Lankton & McKnight, 2009; Meyer, Hickson, Khan, & Walker, 2014; Sweeny & Dillard, 2013; Thompson & Sunol, 1995; Yi, 1990). I believe the disconfirmation theory provides the appropriate theoretical context for my study.

The date parameters for the literature search spanned over twenty years as it was relevant to research reference lists of reviewed articles to find related documents regardless of the date of publication. Additionally, I searched many websites using relevant and not-so-relevant terms and abstracts to find materials relating to this literature review. The following search terms were used for this study: *quantitative, patient perceptions of health care, HCAHPS and nursing care, patient satisfaction, patient experience, quality of healthcare and healthcare, health outcome and healthcare, nursing, nurse and healthcare, patient perception, quality care and satisfaction, nurse/nursing and HCAHPS; HCAHPS and survey and patient satisfaction, and consumer satisfaction, disconfirmation, customer satisfaction, consumer satisfaction and disconfirmation, and HCAHPS and disconfirmation.*

This method resulted in hundreds of thousands of published articles, government reports, and dissertations, of which I reviewed several hundred abstracts and publications for inclusion in this chapter. Criteria for inclusion were that the study data focused on at least one of these topics: patient satisfaction, patients' perception of health care, patients' perception of nursing care, disconfirmation theory, customer satisfaction, confirmation, patient satisfaction, nurses. Particular focus was given to other criteria including Magnet hospital, patient satisfaction with care, the influence of hospital status, and the concept of patient satisfaction relating to Magnet and non-Magnet hospitals.

### **Theoretical Foundation**

The theoretical frameworks for this study are expectancy disconfirmation theory (EDT) and cultural health capital (CHC). The applications of theories are based on

patient satisfaction and dynamics of nursing care. Oliver (1977) proposed EDT to evaluate the consumer post-exposure satisfaction with products as a function of expectations, performance, and disconfirmation. Bourdieu's theory on CHC was redefined by Shim (2010) to address the individual's cultural, verbal and nonverbal skills, attitudes and behaviors, and interpersonal communication.

The rationale for choosing the EDT arrived from its link to the four constructs: (1) expectation, (2) disconfirmation, (3) performance, and (4) satisfaction. These constructs influence each other and are important to explain the relationship between patient satisfaction with nursing care and Magnet-designation based on experience with health services (Ferero & Gomez, 2017; Lankton & McKnight, 2012). In addition, the rationale for using CHC theory centers on the fundamental social inequalities that are evident in clinical interactions. These social interactions can assist nurses, patients, and hospitals to reflect on how such disparities will negatively impact the patient-nurse relationship. Cultural capital is the first embodiment of patient-centered care, influenced by the mutual respect and responsiveness reflected in the relationship between patient and caregiver (Flagg, 2015). This theoretical framework has been used significantly in areas of health care to explain the significance of equity in health care, nurse-patient interaction, and human behavior and attitude (Abel, 2008; Dubbin, et al., 2013; Shim, 2010).

Dubbin et al. (2013) referenced patient care relationships and noted that both patients and providers bring diverse CHC to the care experience. From these different health capitals, patients and providers may find some resources of capital more useful and appreciated relative to others. Dubbin and colleagues further examined features that



provided analysis of cultural capital on how patients and providers used such capital to interact with each other. The researchers found that these clinical interactions can build patient-centered care and relationships. Further, Dubbin et al. (2013) explained that patients value the clinical practice of patient-centered care as it reveals a sense of uniqueness and personalization to the individual. Customization of an individual can result in a positive affirmation of responsibility thus influencing the individual to have a satisfied patient experience.

Recognized as a specific group of valued cultural skills, attitudes, behaviors, and individual habits of patient and provider, the CHC theory seems suitable for this study. When utilized with EDT, the approach had the model that understood clinical interactions and promoted changes in nursing care relationships (Shim, 2010). Through effective interactions with patients, healthcare professionals may become aware of not only the physical, but the social, issues affecting patient care. Shim (2010) believes there is a strong correlation between social status and how patient-health professional interactions are conducted. The theoretical concept of CHC originated from research conducted by Bourdieu (1986), who argued that class and status created culture and social inequalities in healthcare interactions.

### **Literature Review Related to Key Variables and/or Constructs**

In this chapter is a review of the literature relevant to the current study. Boyer and Lutfey (2010) wrote that the patient-provider relationship is the cornerstone of the health care process. Furthermore, interpersonal relationships between health care professionals and patients are important and play a significant role in how healthcare is viewed (Mead

et al., 2008) and how healthcare loyalty is practiced (Richter & Muhlestein, 2017). Over the past thirty years, there have been technological and non-technological changes to the healthcare system (Conklin, 2002; Thimbleby, 2013). Changes such as, giving patients' active role in their health care management, strengthening communities, or revising the traditional insurance payment system. How patients perceive care and their interactions with healthcare providers are only two of the many roles that have become more influential in changing in most hospital settings.

The current literature reviewed the Institute of Medicine (IOM) in a 2001 report, "Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century," as describing the U.S. healthcare delivery system in breach of consistent, high-quality care to all people. The IOM presented six areas of which to re-shape the health care delivery system. However, Corrigan (2005) of the IOM highlighted some of the shortcomings of the 2001 report that proposed healthcare be practiced in a safe, competent, and prompt manner, while respecting the individual patient needs without the presence of disparities. The report did not present patient satisfaction as one of its areas of quality and purposely omitted it because they did not consider it a qualified measure of care.

Despite its exclusion in the IOM (2001) report, many researchers have endorsed patient satisfaction as a qualified measure of quality and patient outcome (Cleary & McNeil, 1988; Donabedian, 1988; LaVela & Gallan, 2014; Needleman & Hassmiller, 2009; Prakash, 2010; Urden, 2002; White, 1999). Some researchers have written against patient satisfaction, and label it a particular measure of quality. Others describe it as

unmeasurable and unobservable because of its subjectivity (Cohen, Myckatyn, & Brandt, 2017; Greaves et al., 2012; Manary et al., 2013; Singh, 1990).

A review of the literature and trends in research related to the determinants that influence patient satisfaction with nursing in-patient care revealed a major gap. This gap demonstrated and rationalized the relevance and the potential influence that Magnet-designation has on patient satisfaction. Today, patients see themselves as consumers of health care services. In turn, hospitals have adopted the consumer satisfaction service model and identified critical components of patient satisfaction and service quality improvements as important hospital functions (Tam, 2004). In today's world of social media and twenty-four-hour news cycle, giving high-quality patient experience in health care is influential in attracting patients (consumers) and improving patients' satisfaction (Backman et al., 2011). According to the Gap model, consumer assessment of service quality results from a comparison of service expectations with actual performance (Zeithaml, Berry, & Parasuraman, 1993).

Hospitals are competing for higher patient satisfaction scores, because strict payment for service guidelines, set by ACA take patient satisfaction into account when estimating reimbursements. If a hospital has high patient satisfaction scores, reimbursement for services will increase (Kutney-Lee et al., 2009; Manary et al., 2013). Conversely, if a hospital has low patient satisfaction scores, reimbursement for services will be reduced. Importantly, Aiken and colleagues (2011) posited that there is a link between patient satisfaction, as derived from HCAHPS, and excellent nursing care. Hospitals with low patient satisfaction scores may indicate that nurses leave necessary

patient care undone due to limited time constraints. Nursing care left undone can grossly affect the quality of care (Lake et al., 2016; Lucero et al., 2009). Meanwhile, high patient satisfaction scores may increase the public perception that the hospital is safe and offers excellent nursing and medical care (Farley et al., 2014; Geiger, 2012; Jha et al., 2008; Kravitz, 1998; Kutney-Lee et al., 2009; Tevis et al., 2015).

My study, therefore, examined whether patient satisfaction with nursing care based on HCAHPS scores is related to Magnet designation. I explored the determinants of quality care and care environment literature to justify the selection of Magnet designation and satisfaction with specific nursing care as variables.

### **Patients as Consumers**

Marketing and healthcare policymakers started giving notice to consumer behavior in the late 1970s and early 1980s. Since then, there has been a growing health care marketing trend that has shifted towards the patient experience relating to satisfaction. This trend recognized the person who sought healthcare services as not only a patient, but a client, a customer, or a consumer with purchasing power and choices (Calabretta, 2002; Naseem, Balon, & Khan, 2001; Ricciardi, Mostashari, Murphy, Daniel, & Siminerio, 2013). Further, Mazurenko, Zemke, and Lefforge (2016) posited that healthcare organizational failure to identify who the customer or consumer is might be one reason for poor patient outcomes. There are many ways to describe the purchaser of a product or service. The healthcare industry defines a patient as the consumer with return potentials. Through the perspective of healthcare consumerism, consumers are often more outspoken about the attention they receive compared to the health care they

should have receive. Patients are equipped with tools, such as social media, the internet, and word of mouth, to circulate and collect information (Hether, Murphy, & Valente, 2014; Hinz, Dreves, & Wehner, 2012). As a result, they make choices and use their voices, often through technology, to express negative experiences or perceptions about healthcare, which can create long-term adverse publicity for health organizations (Backman et al., 2011). The concept of patient experience is difficult, as there is not one acceptable tool to measure patient satisfaction, and the encounter is often multifaceted and more complex than expectations or experiences (Graham, 2016; Iannuzzi et al., 2015; Jaipaul & Rosenthal, 2003; Kutney-Lee et al., 2009).

Various researchers have documented the patient/consumer experience with quality and style of care delivery as satisfaction, while others have documented experience with the organizational culture also as satisfaction (Tsai et al., 2015). Though both are important, they are unequal in many ways and should not use the same measurement tool. This has prompted healthcare organizations to be more responsive to the patient experience and place emphasis on satisfaction (Bleich, Özaltın, & Murray, 2009). In the meantime, patients have expectations of service and make judgments according to perception and actual delivery of care. Gilbert, Lumpkin, and Dant (1992) claimed that patient satisfaction is personal and linked to changes in the competitive health care environment. Individual values, social and cultural factors, and expectations might play a role in the service experience. In addition, hospitals and insurance payers use different patient satisfaction measurement tools to measure value of healthcare delivery and the health care experience. Since 2012, the results of the tools to measure

patient experience, quality care and healthcare outcomes have played an increasingly important role in hospital reimbursements under the ACA (Farley et al., 2014). In addition, hospitals and insurance payers are using different patient satisfaction measurement tools to measure value in the healthcare system. Since 2012, the results of these tools have played an increasingly important role in hospital reimbursements under ACA (Farley et al., 2014).

For hospitals to deliver satisfying, safe, and quality nursing care they require the services of educated and qualified registered nurses (RNs). Nurses are dedicated to ensuring patients receive quality and appropriate care within a safe environment. Most professional health care teams are largely comprised of nurses, that spend a predominant amount of time with patients compared to other staff. The goal of nurses is to use their knowledge and expertise to ensure that patients receive safe and quality care (Havens & Aiken, 1999).

In the 1990s, reports of staff shortages, poor working conditions, and increased workload for nurses in hospital settings dominated the media (Aiken, Clarke, Cheung Sloane, & Silber, 2003; Laschinger, Almost, & Tuer-Hodes, 2003). Hospitals actively responded to find ways to address problems with nursing shortages and promoted patient satisfaction (McClure, Poulin, Sovie, & Wandelt, 1983). Organizational executives and policy makers promoted hospitals with Magnet-designation as places with less nurse burnout, better working conditions, and higher patient satisfaction rates (Aiken, Havens, & Sloane, 2000; Kramer & Schmalenberg, 2008; Laschinger, Shamian, & Thomson, 2001).

On the other hand, some researchers have shown that nurses are attracted to Magnet-designated hospitals because of the work environment and organizational cultural characteristics that allow them to be autonomous in a professional setting (Kramer & Schmalenberg, 2003; Van den Heede et al., 2009). More importantly, research findings have documented that hospital stakeholders, policymakers, and hospital leaders have concluded that nursing care has an impact on patients' satisfaction (MacLeod, 2012). Thus, my study aims to explore if Magnet designation has any relationship to patient satisfaction with nursing care via the HCAHPS.

### **Healthcare Organizations and Patient Satisfaction**

The growth of research on customer satisfaction or dissatisfaction with service started when the business community examined the relationship between quality service and consumer or customer satisfaction and expectations (Cardozo, 1965). Patient satisfaction with the healthcare encounter became publicized as a measurement of how health service is delivered. Since the 1980s, many healthcare organizations have used patient satisfaction as a determinant of quality care. Pascoe (1983) reasoned that satisfaction revealed patients' subjective impression of the quality of care and expectation of it. Further, Kravitz (1998) explained that in healthcare, the need to quantify and describe the patient experience became two of the principal instruments to measure satisfaction. The concept of patient satisfaction continues to be considered an important aspect of patient outcome measures for health services. Patients' satisfaction has been researched and studied from many different angles, wherein Kravitz (1998) argued for narrative modification in tools that measured it. Initially, the narrative must decide what

to measure, goods or services? Patients have different ideas that they bring to the satisfaction argument. Questions relating to patient satisfaction are complex, and patients have to invest social and mental resources when answering questions. Patient satisfaction is not a solitary design, it is a mixture of perceptions and values. Sofaer and Firminger (2005) describe patient perceptions as differences in attributes of expectation or what is experienced. Kravitz (1998) describes values as the importance patients place on their expectations and experiences. The narrative of patient satisfaction with healthcare should not be based on ambiguous language. Thus, if the goal, for hospitals is to measure patient's satisfaction it is critical that questions be structured according to differences in experiences and other expectations that may give patients an unambiguous understanding of the relevant event (Kravitz, 1998). Other authors have studied patient satisfaction and established its relationship to nursing and quality care (Kutney-Lee et al., 2009; Scardina, 1994), while others focused on patient satisfaction as it is related to patient expectations (Hill & Doddato, 2002; Lynn & McMillen, 1999).

Today, most business industries are concerned with customer satisfaction. The healthcare industry is no different; it too promotes satisfaction as an emblem of quality. According to previous literature, many hospitals decided to change how they delivered healthcare in order to affect patient satisfaction (Bowen, Lyons, & Young, 2000; Conklin, 2002; Jaeger, 1990). First, hospitals and other healthcare agencies had to re-evaluate business practices. Second, they had to comply with the restructuring of care delivery. Lastly, they promoted adjustments within the organizational culture to sustain changes (Bowen et al., 2000).



In 2001, the Institute of Medicine (IOM) distributed a report on a new healthcare concept. The author of the healthcare report, 'Crossing the Quality Chasm: A New Health System for the 21st Century Healthcare,' visualized a healthcare system that would change patient care and improve health outcome (Gold, 2007). To improve the standing healthcare delivery structure, the IOM categorized six objectives for healthcare: safety, effective, patient-centered, timely, efficient, and equitable (Gold, 2007). Achieving these six objectives, the IOM suggested would help health care organizations to be ready to meet the needs of any patients.

For example, minority populations have contended with dissatisfaction from the nation's healthcare system for decades. This contention, often experienced by African Americans, is in part related to the history of slavery, hospital segregation, and ongoing health disparities (Brooks-Carthon et al., 2011; Nelson, Stith, & Smedley, 2002). Even though the practices of implicit and explicit bias continue, researchers have documented many ways to improve satisfaction among minority groups. Particularly, one such remedy focuses on techniques to restore minorities' trust of the health system (Shavers et al., 2012). Additionally, trust in racial and cultural differences and promoting racial likeness between patients and healthcare providers could improve minority patient healthcare satisfaction (LaVeist & Nuru-Jeter, 2002). In practice, these techniques could help to lessen the occurrences of patient dissatisfaction. Even though patients spend more hours with nurses, there is a significant amount of research focusing on the physician-patient relationship. There are limited amounts of research documenting nurses as providers and how satisfied minority patients are with their received care (Blendon,

Aiken, Freeman, & Corey, 1989; Morse, 1991; Morse, 1997; Saha, Arbelaez, & Cooper, 2003).

Researchers have also recognized that there are substantial differences between ‘patient satisfaction’ and ‘patient experience’ as tools to measure quality of care. In most hospitals, nurses are charged with the primary care of patients; thus, their attitudes and behaviors are persuasive in the overall patients’ perception of quality and satisfaction (Jha et al., 2008; Kutney-Lee et al., 2009; Otani et al., 2009; Radtke, 2013; Smith, 2014). While there are large bodies of literature linking physicians to patients’ perception of care (Blair, Steiner, & Havranek, 2011; Duffy, Gordon, Whelan, Cole-Kelly, & Frankel, 2004; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Nelson et al., 2002), little is known about how patients perceived the nurses and the nursing care they have received (Kutney-Lee, 2009).

In contrast, there is a growing amount of literature connecting nurses to quality health care and nursing care of patients. However, little is documented about how nurses influence the patients' perception of quality care and satisfaction (Aiken et al., 2002; Burhans & Alligood, 2010; Needleman & Hassmiller, 2009). More than any other health care providers, nurses are poised at understanding that patients' perception of the hospital encounter is fundamental to improve how quality care is delivered. Fundamental teachings in the nursing curriculum have placed importance on the human-to-human interactions with patients (Burhans & Alligood, 2010). Currently, more than previously, nurses are dealing with patients from many different backgrounds, and are encouraged to

be culturally competent, more educated, and to deliver care using a more patient-centered approach (Black, Soelberg, Springer, 2008; Loftin, Hartin, Branson, Reyes, 2013).

### **Patient Satisfaction With Nursing Care**

Patient satisfaction with nursing care has become a significant measure of quality care. In nursing, quality care is evaluated with patient satisfaction tools to measure experience outcomes. Patient satisfaction tools, such as surveys and questionnaires, measure care delivered by nurses and are used to improve or make changes where needed to reach a higher level of patient satisfaction (Aiken et al., 2009; McHugh et al., 2012; Silber, Krahn, & Morgenthaler, 2016). As a measurement of quality, patient satisfaction is used to determine reimbursement rates according to positive or negative outcomes (Farley et al., 2014; Geiger, 2012).

In today's consumer-driven market, hospitals are competitive and depend on delivering quality services to retain consumers. Patient satisfaction with nursing care is an essential indicator of such services (Schmidt, 2003). However, patient satisfaction is subjective, and measurements should be developed with some degree of patient input on quality of nursing care and experience of the healthcare encounter (Larrabee & Bolden, 2001). Therefore, to better meet patients' needs, healthcare organizations should use patients' expressed concerns to complement care delivery and other practices of quality commitment and expectation of care (Cleary et al., 1991).

The study of patient satisfaction has been linked to nursing, quality care, structural hospital characteristics, and patient outcomes (Brooks-Carthon et al., 2011; Sharma & Kamra, 2013; Yellen, 2003). Furthermore, satisfaction has been featured in

research involving other disciplines, such as economics, policy, psychology, and marketing, to highlight changes in healthcare. The core of the literature reviewed underscored the concept that patients' satisfaction is not insular; patient satisfaction is determined by various factors associated with the agents involved in the experience. For example, from the patients' perspectives, researchers have established relationships between patient satisfaction and patient's age (Jaipaul & Rosenthal, 2003), caregiver cultural competence (Weech-Maldonado et al., 2012), patients' race (Barr, 2004; O'Brien, & Shea, 2011), and patient's health condition (Otani, Waterman, & Dunagan, 2012).

Another perspective comes from the nurse as the caregiver; some literature focused on the relationships between patient satisfaction and nurse staffing ratio (Kutney-Lee, et al., 2009), nurse-patient communication (Klinkenberg et al., 2011; Swan & McGinley, 2016), nurse response to patient needs (Klinkenberg et al., 2011), and care environment (Kutney-Lee et al., 2009). These studies have all established significant relationships between patient satisfaction and nursing care. However, the current implication in the literature is focused on patient satisfaction as it relates to nursing care and its potential relationship with Magnet designation (Stimpfel et al., 2015).

Berhane and Enquesslassie (2016) posited that patients seeking health services have an identifiable list of concerns and problems they want health caregivers to deal with, which may include their expectations and desires of care. Chenard (2014) explained that the rise in interest of patient satisfaction is a remarkable phenomenon which is influenced by internal (patient experience) and external factors (social and economic). MacLeod (2012) and Wagner and Bear (2008) agreed that nursing care is one

of the chief determinants of patient satisfaction with their hospital encounter.

Organizational bureaucracies described the healthcare encounter as a service and the patient as the consumer to be satisfied while using responsible financial standards to do so (Chenard, 2014). In addition, the role of the nurse caring for patients will sometimes conflict with the hospital bureaucracies and culture and, as a result, it may have a positive or negative influence on patient satisfaction. Meanwhile, the fundamental principle of most healthcare organizational marketing is to deliver quality service and have satisfied patients, while acquiring and maintaining patient's loyalty for long-term profitability (Alford, 1998; Atkins, Marshall, & Javalgi, 1996; Hallowell, 1996; Richter & Muhlestein, 2017).

Pascoe (1983) reasoned that satisfaction reveals patients' subjective impression of quality care and expectation. Later, Calnan (1988) added that empirical research related to patients' perception of quality of health care has languished from gaps. Further, Carr-Hill (1992) added there are difficulties involved in the development and design of a comprehensive conceptual model of patient satisfaction surveys. However, Avis, Bond, and Arthur (1997) questioned patient satisfaction and how it is used to measure health services. The researchers argued that there are reservations about the validity of patient satisfaction as a measurement of healthcare services. Avis et al. (1997) theorized that the model of patient satisfaction produced a limited understanding of how patients judge their care and advised that a less structured approach may be helpful in getting patients' perspectives. Meanwhile, Kravitz (1998) explained that in healthcare the need to

quantify and describe the patient healthcare experience had become one of the principal instruments to measure satisfaction.

Based on the social psychological theory Linder-Pelz (1982) explained that patient satisfaction is an expression of their subjective evaluations to distinct situations of health care. Eriksen (1987) however, revealed that an inverse relationship between quality of nursing care and patient satisfaction. Eriksen warned that nurses should use caution in relating patient satisfaction to quality of nursing care. In contrast, Bell, Krivich, and Boyd (1997) explained that measuring patient satisfaction is a valuable measuring tool as it provides useful information to healthcare managers on weaknesses and strengths in how they design, develop and react to the patient outcome. Bell and others (1997) further added that as a subjective indicator, and as a measurement tool, patient satisfaction is a proven central variable to other outcome measures. Crow et al. (2002) described satisfaction as the gap between patient's expectation and the care actually received.

Otani, Kurz, Harris, and Bryne (2005) set out to identify which attributes most impact patient satisfaction and which features of each attribute is most vital to the response of the service patient received. Otani et al. (2005) found that nurse behavior, such as courtesy, respect, sensitivity, and friendliness, was vital to patient satisfaction. The researchers pointed out that although satisfaction with quality of care is subjective, this evaluation urges the patient to return or recommend others to do business with the organization that cared for them (Hayes & Tyler-Ball, 2007). In contrast, patient with poor satisfaction will seek care elsewhere and may impact others to do the same. In

addition, they may relay their negative experiences to others (Kessler & Mylod, 2011; Otani et al., 2005). Despite the lack of verification of information by some users and influence of social media, health care organizations continue to use patient satisfaction as a measuring tool to maintain their competitive edge.

The influences of patient satisfaction as a measure of quality is now considered an essential aspect of patient outcome measures for health services (Yellen, 2003; York & McCarthy, 2011). To explain the relationship between patient (consumer) satisfaction and service, this study uses the EDT and CHC theories. Some researchers suggested consumer satisfaction is directly related to expectations and have a direct effect on the disconfirmation process (Swan & Trawick, 1981; Tse & Wilton, 1988). Researchers who have compared patient satisfaction in Magnet-designated hospitals to non-Magnet hospitals suggested patients' expectations were higher in Magnet environment as patients may focus more on nursing skills (Van den Heede et al., 2009). Meanwhile, Stein, Day, Karia, Hutzler, and Bosco (2014) argued that there is no clear evidence that linked patient satisfaction to quality technical skills. However, patient centered care drives higher satisfaction and lower complication rates; and patient experiences are, usually linked to the care received (Stein et al., 2014).

### **Magnet Designation Program**

Magnet designation is a nationally recognized program awarded to hospitals meeting criteria for achievement of nursing excellence while delivering quality and safe nursing care. Magnet-designation is often applied to hospitals that can attract and retain nurses. Hospitals that successfully meet ANCC criteria and demonstrate high standards

are awarded designation (Kaplow & Reed, 2008). Magnet-designation not only recognizes staff nurses, but it also focuses on the chief nursing officer (CNO) who must be in his/her job for twelve months before initial application to ANCC and meet approved educational requirements. Further, there must be evidence of the CNO's active participation in decision-making, professional oversight and planning and executive-level involvement. The Magnet Recognition Program was created by the ANCC, a nonprofit branch of the ANA in 1990 (ANA, 2018, para. 1). In the late 1970s and early 1980s, there was a chronic shortage of nurses in the United States (Kramer, 1990; McClure et al., 1983). Nurses were nomadic and restless; policy makers became curious, and researchers performed studies to investigate why some hospitals retained nurses while others did not (Havens & Aiken, 1999; Houser, 2005; Laschinger, Almost, & Tuer-Hodes, 2003; Upenieks, 2005). However, researchers found that despite the national shortage in healthcare staffing, several hospitals thrived. Generally, these researchers found that there was higher nurse retention, higher patient satisfaction rates and less nurse burnout. For example, hospitals that gave nurses more control in the practice setting had higher rates of patient satisfaction (Aiken, Sloane, & Lake, 1997). In addition, hospitals with Magnet-designation achieved better outcomes than comparable non-Magnet hospitals (Havens & Aiken, 1999).

Amid the nursing shortage, the American Academy of Nursing (AAN) founded a task force to investigate why some hospitals were successful at employing and retaining nurses while others were not. The AAN taskforce endorsed a study to identify factors that were unique to these hospitals so that other hospitals could reproduce those factors and



success (McClure et al., 1983). The AAN identified 41 hospitals that had specific characteristics for effectively employing and maintaining nursing staff during the shortage (Lash & Munroe, 2005; Upenieks, 2003). These hospitals were designated as 'Magnet' in 1983, because of their accomplishments in appealing to and magnetizing nurses (Goldberger, Kruse, & Stender, 1987). Several researchers have identified certain characteristics common to hospitals designated as Magnet, such as involving qualified nurse leaders of all levels in decision making processes. Additionally, these hospitals have organizational structures that give nurses the opportunity to participate in policymaking, foster autonomy among themselves, and provide governance over practice settings. These hospitals create a climate that acknowledge nurses' clinical expertise and recognize the value of their practice to healthcare and patient outcome. They readily accommodate staffing schedule and provide adequate staffing to ensure quality care. Lastly, these hospitals offer clinical career prospects and other opportunities for nurses and other staff (Armstrong & Laschinger, 2006; Kaplow & Reed, 2008).

After the initial Magnet study, the American Nurses Association (ANA) was created, in 1981, so that any hospital wishing to receive Magnet-designation had a structured application process. However, hospitals must follow strict rules set by the ANCC through an application system, and then hospitals are evaluated against criteria remotely and through onsite evaluations. The hospitals can then proceed further with the Magnet standards that lead to recognition (Weeks, Smith, & Hubbartt, 2006). The Magnet-designation process is long and laborious and involves intense participation from members at all levels of nursing. First, there is an application process during which the

organization must provide a submission detailing the different qualitative and quantitative examples showing the relationship between effective nursing care and successful patient quality outcome. Next, the implementation of support systems for professional nursing advancement is presented. If the submission scores are favorable and falls inside the established range of excellence, an on-site assessment of the organization is done to evaluate the hospital. The results are then assembled and reviewed by the Commission on Magnet Recognition. This Commission analyze the final assessment report and elect to award the four- year status of Magnet designation (Thomas & Herrin, 2008). As of 2017, there are 460 Magnet-designated hospitals in the United States (ANCC, 2017).

Organizations that achieve Magnet-designation status earn the credibility to use the Magnet Trademark logo. In 2007, through its continued quest for excellence in nursing care, the ANCC embarked on a new Magnet model to better demonstrate a general argument of globalization in healthcare and nursing (Messmer & Turkel, 2011). The new Magnet model, implemented in 2009, has five components that are based on empirical research as described by the ANCC (Messmer & Turkel, 2011). Prior to the implementation of the new model, the Magnet Recognition Program recognized and defined the characteristics of healthcare organizations, the “14 Forces of Magnetism”, which are supportive of environments that are conducive to recruiting and retaining professional nurses (Morgan, 2007).

The ANCC described the “14 Forces of Magnetism,” as: “(1) quality of nursing leadership, (2) organizational structure; (3) management style, (4) personnel policies and programs, (5) professional models of care, (6) quality of care, (7) quality improvement;

8) consultation and resources, (9) autonomy, (10) community and health care organizations, (11) nurses as teachers, (12) image of nursing; 13) interdisciplinary relationships, and (14) professional development”(Forces of Magnetism, 2005).

### **New Magnet Model**

The new Magnet model adopted in 2009 is comprised of the original “14 Forces of Magnetism” that were restructured to shape the foundation of the program. The goal of this restructured process is to change global healthcare dynamics that may create challenges currently confronting nursing and healthcare organizations (Thomas & Herrin, 2008). After evaluating the impact of magnetism on nursing practice the AAN choose to narrow the qualities to five core groups. The association decided to promote transformational leadership and uphold structural empowerment by maintaining exemplary professional practice, through new knowledge, and innovation and continued empirical research (Wolf, Triolo, & Ponte, 2008). Further, Wolf et al. (2008) explained the new Magnet model would serve as the foundation of evidence-based practice, knowledge, and expertise for the delivery of nursing care globally. In addition, organizational executives should disseminate data supportive of the Magnet designation process. As leaders, they are expected to promote the message of change within the organization and to all involved. Ultimately, leadership must emphasize to the team that success of the Magnet journey finally is to improve organizational recognition, increase nursing satisfaction, patient satisfaction, and clinical outcomes (Messmer & Turkel, 2010).

## **Magnet Designation and Outcomes**

Previously, research to compare patient outcomes between Magnet designated and non-Magnet hospital was done using organizational characteristics to account for differences (Friese, Xia, Ghaferi, Berkmeier, & Banerjee, 2015). Kramer and Schmalenberg (1988a) focused on how Magnet-designation practices in the 1980s were like corporate-run companies and as a result, had better patient outcomes. Other researchers were concerned with characteristics of structural differences and patients' outcomes (Haven, 2001). Amid an increasing focus on Magnet-designated hospitals, Aiken et al. (1994) started seminal research to ascertain whether hospitals with Magnet recognition are associated with better patient outcomes compared to non-Magnet hospitals.

Aiken and colleagues (1994) explored the mortality rate of Medicare patients in Magnet-designated compared to non-Magnet hospitals that were similar in non-nursing organizational features. The results showed Magnet-designated hospitals had 7.7% less mortality before adjusting for projected mortality and 4.6% after adjustments. Magnet-designated hospitals have lower Medicare mortality rates than non-Magnet hospitals relating to determinants in nursing. The researchers used 39 hospitals that were identified as Magnet-designated because of organizational purposes, not nursing care. These hospitals were paired up with 195 non-Magnet hospitals, and the researchers ran a secondary analysis using a multivariate method to compare the two samples while adjusting for predicted patient mortalities (Aiken et al., 1994). Aiken and colleagues (1994) established that the 30-day mortality rate were lower in Magnet-designated

hospitals compared to non-Magnet hospitals. This study was crucial to show the benefit of Magnet designation, as there were other factors associated with the hospital setting that were contributing to the care delivered (Curtin, 2003). The researchers agreed that the collection of organizational characteristics possessed by Magnet-designated hospitals, compared to those without designation, led to a culture in which nurses report more freedom and influential input for patient bedside care, as well as stronger nurse-physician relationship (Aiken, Clarke, & Sloane, 2002).

A second study by Aiken and associates (1997) focused on the understanding of the connection between organizational characteristics and outcomes. The researchers tested the connection concept and proposed a 20-hospital study to determine how structural traits, such as nurse-patient ratio, contributed to outcomes for Acquired Immune Deficiency Syndrome (AIDS) patients and their nursing caregivers. The researchers chose three different kinds of inpatient models of AIDS organizational care: hospitals with approved AIDS unit, Magnet-designated hospitals without approved AIDS unit, and non-Magnet hospitals with patients on typical medical units (Aiken et al., 1997). The study showed approved AIDS unit and Magnet-designated hospitals were valuable to AIDS patient care and, compared to non-Magnet hospitals without approved AIDS units, demonstrated a lower 30-day mortality rate (Aiken et al., 1997). In conjunction, patients benefited from improved nurse staffing, physician specialization in AIDS care, and stronger nurse autonomy (Aiken, Lake, Sochalski, Sloane, & Weber, 1999).

On the other hand, van Servellen, Lewis, Leake, and Schweiter (1991) examined patients' satisfaction with their nursing care in seven hospitals where five of the hospitals

used special care units (SCUs) to deliver care to AIDS and oncology patients. The researchers found that patients on SCUs for AIDS and oncology patients revealed higher satisfaction with their care than on integrated units with medical, oncology and AIDS patients. This revelation may challenge the significance of patient satisfaction from Magnet hospital and place it on units devoted to specialized care rather than integrated units. Similarly, another study by Aiken et al. (1997) found that patients receiving care on devoted AIDS units revealed greater significance with nursing care than patients on integrated units.

There are currently many arguments in healthcare that support the need for nurses to be better educated to meet the challenges of global and diverse communities. For example, baccalaureate nurses are educationally prepared to elicit better patient outcome (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Black, Soelberg, & Springer, 2008) and lower mortality rates (Aiken et al., 2003; Friese, Lake, Aiken, Silber, & Sochalski, 2008). Magnet-designated hospitals have placed importance on nurse practice environment and patients' outcomes. Investigators have reported Magnet-designated hospitals showing decreased odds of mortality and failure to rescue. Higher rates of certified nurses were linked to the study as a contributing factor (McHugh et al., 2013). A specialty in nursing practice and increased advance nursing among nurses has been related to improved patient outcomes. For many years, the IOM has been advocating for an improved patient outcome and has recommended higher educational preparation for nurses as the key to any challenges in nursing (Kovner, Brewer, Katigbak, Djukic, & Fatehi, 2012).

Magnet-designated hospitals have an increased proportion of baccalaureate-prepared and specialty trained nurses compared to non-Magnet hospitals (Blegen, Goode, Park, Vaugh, & Spetz, 2013; Schuelke, Young, Folkerts, & Hawkins, 2014). Mortality among surgical patients are 20% lower in Magnet-designated hospitals than non-Magnet hospitals because of the high proportion of nurses with better educational preparation, specialty certificates, and advanced degrees. Specialty certification and life-long learning reinforce patient outcome by supporting consistency in nursing practice (Boyle, Cramer, Potter, Gatua, & Stobinski, 2014; Williams, Lopez, & Lewis, 2013).

Boyle et al. (2014) examined the relationship between the level of specialty certification (e.g., clinical care specialist, perioperative nurses, surgical intensive care nurses), and patient outcomes depending on quality and quantity of nursing care. The researchers were the first to link nursing specialty with patient outcome. The researchers found that nursing certification contributed considerably to patients' outcomes after controlling for hospital characteristics and unit specifics. On the other hand, some researchers found there is no relationship between patient outcome and nurse specialty education. A study of certified RNs by Kendall-Gallagher and Blegen (2009) revealed certifications were inversely related to falls and the number of years of experience of RNs on units was also inversely related to the frequency of urinary tract infections (UTIs). In addition, another study of certified and non-certified nurses found little support for the assumption that nursing care by oncology certified nurses produce superior patient outcomes compared to non-certified nurses (Frank-Stromborg et al., 2002).

In addition to advanced degrees, researchers have found adequate nurse staffing contributes to a positive patient outcome (McClure et al., 1983). McClure and colleagues (1983) identified nurse staffing, nurse autonomy, and physician-nurse collaboration as some of the leading attributes of a positive nursing work culture in Magnet hospitals. Researchers have found staffing, and work environment are significant factors that affect nurses' intent to remain in their jobs (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). To capture the nurses' perception of their environment and provide some understanding of workforce authority, Kramer and Hafner (1989) launched the Nursing Work Index (NWI). A 65-item instrument, NWI was designed to measure organizational attributes that inspire job satisfaction and perceived efficiency.

Many years of research have revealed the concerns of nurses to hospital management about poor nurse-patient staffing ratio and the impact of nurse shortage on moral. Further, they continuously verbalized matters relating to hospitals restructuring and changes in staffing arrangements (Aiken & Sloane, 1997). Hospitals were concerned with lowering cost which was increasing at about 2% each year. As the largest group of healthcare workers nurses were concerned that attempts to lower cost could have a tremendous effect on their delivery of care (Needleman & Hassmiller, 2009). Particularly in the 1990s, nurses had widespread concerns regarding the poor staffing ratio and its effect on patient care and the lack of new recruits joining the profession (Needleman & Hassmiller, 2009). Despite the nurses' concerns, the IOM (1996) reported on nurse staffing in the hospital and found there was limited empirical evidence to support the subjective and other unconfirmed data that hospital restructuring was interfering with



nurse staffing (Needleman & Hassmiller, 2009; Wunderlich, Sloan, & Davis, 1996). However, the nurses' concerns moved Congress to act in 1999, launching a study to investigate the capacity of hospital nurse staffing. Results supported positive relationship between adequate nurse-patient ratio and patient healthcare results. Researchers, such as Aiken et al. (2002a), encouraged the need to improve patient to nurse ratio; this change allow nurses to deliver quality patient care and hospitals to maintain satisfied nurses. Hospitals with disproportionate patient to nurse ratio, demonstrate higher rates of patient mortality and nurse burn out. California became the first state to authorize a minimum hospital patient-to-nurse ratio (Aiken et al., 2002a).

Evidence continued to build and Van den Heede et al. (2013) discovered that appropriate nurse patient ratio staffing in post-operative care units has resulted in lower mortality rate. Similarly, Kane, Shamiliyan, Meuller, Duval, and Wilt (2007) agreed that there was significant statistical and clinical relationship between nurse staffing and patient mortality. Other researchers have argued that organizational characteristics affect nurse and patient outcome (Aiken et al., 2002a). Nurse-patient ratio is extremely important to prepare for Magnet-designation. Following Magnet designation achievement, hospitals are acknowledged for supporting safe and appropriate nurse staffing, which most often results in positive patient outcomes (Hairr et al., 2014).

Leiter, Harvie, and Frizzell (1998) surveyed nurses and patients to determine whether patient satisfaction (overall hospital care) relates to nurse mental and physical fatigue, intent to sever employment, and significance of work. These data are comprised of two hospitals, 16 inpatients units, 605 patients, and 711 nurses. Researchers gave the

patients the Patients Judgment of Hospital (PJH) questionnaire, modified by the Conference Board of Canada. Researchers gave nurses the Maslach Burnout Inventory general survey, which assesses burnout amongst professionals with and without direct patient contact. Results showed that when nurses reported high significance in their work, patient also reported higher satisfaction in all areas of care. Conversely, patients were less confident with various elements of care and overall hospital stay when they were on units where nurses reported being burnt-out and often expressed the desire to leave (Leiter et al., 1998).

Years after Leiter and colleagues' study (1998), Vahey, Aiken, Sloane, Clark, and Vargas (2004) conducted a similarly cross-sectional study with a national sample of nurses and patients from 20 urban hospitals to assess the effects of work culture and nurse mental and physical weariness on patient satisfaction with their nursing care. The researchers used the Revised Nursing Work Index (NWI-R) and Maslach Burnout Inventory (MBI) to measure nurse work environments and nurses' intention to leave jobs. The researchers interviewed patients using the La-Monica Oberst Patient Satisfaction Scale (LOPSS) to evaluate satisfaction with nursing care. Results showed increased patient satisfaction with care when they were cared for on units with appropriate staffing, such as an adequate nurse to patient ratio. In addition, patients were more satisfied on units with excellent administrative support for nursing care than units with less supportive administrative staff. Furthermore, patients also report higher satisfaction on units where nurses report lower burnout and having good working relationships with physicians.

## **Development of Instruments for Measuring Patient Satisfaction**

For decades, patient satisfaction has been recognized as a meaningful quality care standard (Cleary & McNeil, 1988). Nevertheless, the majority development of patient satisfaction tools was developed without emphasis of patients' and families' perspectives (Beattie et al., 2015; Chang, 1997). Beattie et al. (2015) emphasized that measurement is important to improving quality of hospital care. Further, dynamic analysis of patient experience that sorts out facts of care experience from the complexity of the hospital encounter was needed (Beattie et al., 2015). Prior to the full development of HCAHPS instrument, AHRQ and other groups affiliated with CAHPS used a careful and meticulous process to include public input (patients and families). Various methods were used to test and revise the HCAHPS measure including public calls for other measures, literature review, consumer focus groups, cognitive interviews, and consumer testing. Meanwhile, CMS allowed the public three opportunities to give their comments on HCAHPS. As a result, CMS responded to over one thousand comments (HCAHPS Fact Sheet, 2015).

Some researchers have measured patients' perceptions of nursing care using patient satisfaction standards based on knowledge of care quality constructed from nurses' and patients' perspectives. While other measurement tools are developed with input from the nurses and patients (Goldstein, Elliott, & Guccione, 2000; Kear, Harrington, & Bhattacharya, 2015; Lynn McMillen, & Sidani, 2007). The AAN, the IOM, and the AHRQ all agreed that the patients' perception of care is an essential indicator of healthcare quality (Mitchell, Heinrich, Moritz, & Hinshaw, 1997). However,

not all instruments developed to measure patient perceptions are equal and valid to measure patient satisfaction.

For example, Dozier, Kitzman, Ingersoll, Holmberg, and Schultz (2001) created an assessment of nursing quality based on patient impression of their experience. Patient Perception of Hospital Experience with Nursing (PPHEN), an instrument to measure patient perceptions of nursing care quality. The researchers asserted that the instrument was not focused on patient satisfaction in which a comparison is made between what is expected and what happened. Dozier et al. (2001) steered the instrument toward the concept of patient perceptions of needs being met. Further, PPHEN does not require patients to compare their expectations of care with the care received; instead, it requires them to evaluate whether their needs were met. Perception of care is the concept that brought about the HCAHPS instrument that attached hospitals to "top box" and hospital reimbursement of the hospital to patients' survey scores. Even though Hospital Compare reports all boxes (top, middle and bottom) top box scores only incorporate the most positive responses to HCAHPS Survey questions. However not all hospitals that achieve top box scores will receive 5-star ratings. One of several measures of service quality, SERVQUAL, is a 22- item instrument developed for the retail industry where each business competed to differentiate themselves as better than their competitors (Parasuraman, Zeithaml, & Berry, 1988). The SERVQUAL measure was utilized to assess customer perception of service in marketing and value of inpatient nursing care at discharge (i.e., service, communication, and design; Newell & Jordan, 2015; Scardina, 1994; Siddiqui, Zuccarelli, Durkin, Wu, & Brotman, 2015). Unlike a variety of goods, it

is difficult to measure individuals' subjective perceptions of the hospital care they received. Nonetheless, SERVQUAL focuses on some of the same constructs that the healthcare field uses to measure its concept of quality as an outcome measure.

SERVQUAL measures perception and expectation of services from five proposed elements (Parasuraman et al., 1988). These elements are consistency, prompt customer care, support, compassion, and physical characteristics. The first four elements reflect the human aspect of service performance, while the fifth, tangibles, reflects the physical environment of the setting being assessed. Measurement of quality in a service industry such as healthcare can be difficult to obtain, as the evaluation of the performance is subjective. However, Parasuraman, Berry, and Zeithaml (1991) explained that quality of service is constructed from the difference between consumer expectation and what they receive. As nursing care is one of the foremost determinants of patient satisfaction measuring how it affects patient is essential to its delivery. Several researchers have concluded that patient satisfaction is multi-dimensional (Richard, 2000), complicated (Patterson & Marks 1992), and requires a multidimensional tool like SERVQUAL (Richard, 2000). Since its inception in 1977, SERVQUAL and other measuring devices such as the HCAHPS have demonstrated utility in measuring patient satisfaction and helping to inform changes and training in the healthcare industry (Richard, 2000). Researchers use this tool to assess patient perceptions and expectations in order to evaluate and measure patient satisfaction with nursing care (Scardina, 1994).

Another instrument, Patient Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ), is a Canadian patient-centered questionnaire adopted from the American-

created Patient Judgment of Hospital Quality (PJHQ) instrument (Laschinger, Hall, & Almost, 2005). The PSNCQQ was developed to capture the patients' perspective of hospital quality and reflect patients' satisfactions with components of nursing care (Baumann, Rat, Mainard, Cuny, & Guillemin, 2011). The PSNCQQ is a 19-item tool used to assess satisfaction while the patient is still admitted and receiving nursing care, general nursing care quality, and willingness to express favorable intent to return (Hill & Doddato, 2002). Given the wide spread competition and the need for consumers to choose their healthcare plans and physicians it is significant to have nationally established reporting databases that collect information for public use. Increase growth in the need to evaluate patients' healthcare experience and the enormous benefit in publicly reporting the information can aid in how health agencies respond to evidence of negative or positive review (Price et al., 2014). As a nationally recognized public reporting database, secondary data from HCAHPS survey was used in this study as the measuring tool for patient satisfaction with nursing care.

### **HCAHPS as a Measurement Tool Used for Quantification**

Patients' expression of their hospital experience can be personal and pose persistent challenges for healthcare institutions to measure. Feedback of patients' hospital experience makes hospitals competitive and improves their quality of care. For hospitals, exceptional quality of care is important as it leads to improved patient satisfaction, patient loyalty, and economic success. There are many different instruments available to measure the patient hospital experience. Some tools are specific to certain regions, populations,

and facilities, and some are developed or adapted from pre-existing instruments (Castle, Brown, Hepner, & Hays, 2005).

Over several decades, researchers have been exploring instrument content, method of administration, and implementation to determine which ones are best suited to measure patients' hospital experience quality and satisfaction. Using the right tool to measure quality care can improve satisfaction, and improved patient satisfaction results in the hospital receiving coveted recognition from public and private regulating agencies (Friedberg, Steelfisher, Karp, & Schneider, 2011). For example, the Hospital Quality Alliance (HQA) is responsible for monitoring hospitals to ensure that they administer efficient care and services without harm to patients with frequently diagnosed conditions. Although the information supplied by HQA is freely available to the public, it is from the hospital's perspective and not the patient. The hospitals report information to HQA that is taken from patient's discharge data for only three specified diagnosis (pneumonia, acute myocardial infarction, and congested heart failure). So, to give the public a voice in how they perceive quality and satisfaction, HQA added the Consumer Assessment of Health Plans Study (CAHPS) to its established alliances (Hospital Quality Initiative Overview, 2008; Jha, Li, Orav, & Epstein, 2005).

The HCAHPS survey is a nationally established questionnaire that can be administered as an independent survey or used in conjunction with other chosen question sets by the hospital. The HCAHPS survey began as CAHPS, which is a registered trademark and was developed to ask patients and consumers about their encounter within the health care system (CAHPS®: Assessing Health Care Quality from the Patient's

Perspective). Over several years, CAHPS has evolved and became HCAHPS and is presently controlled by the AHRQ to keep it relevant in measuring how patients perceive their healthcare (Elliott, Edwards, Angeles, & Hambarsoomians, 2005; Goldstein, Farquhar, Crofton, Darby, & Garfinkel, 2005).

As of 2008, hospitals must participate in HCAHPS to qualify for full reimbursements of inpatient claims from CMS; lack of participation results in a 2% reduction in payment. Additionally, participation in HCAHPS was linked to Inpatient Prospective Payment System (IPPS). This pay-for-performance (P4P) system ensures quality is scrutinized for standardized measurement while indicating patient satisfaction and supports cost-effective health care. Three overarching goals molded HCAHPS. The first goal focuses on patients' perspectives of care and generate data from patients so that salient information can be shared. The second goal is to create new incentives for hospitals to improve quality of care. The third goal is based on increasing transparency of how quality care is managed in an effort to improve organizational accountability improvements.

The HCAHPS survey was developed to measure patients' hospital inpatient experiences within acute care hospitals. It is the standard data collection and measuring tool with which CMS measure patients' perception of inpatient care and uses it to compare hospitals to hospitals. Information on the HCAHPS website is free and accessible to the public. Because the design standards of the HCAHPS survey are comparable among hospitals, it allows the hospital surveys to be reliable, credible, and



useful across the broader healthcare system. The survey is standardized and needs to show consistency so that policies and programs are based on the validity of the results.

### **Responsiveness of Staff**

Patients view staff responsiveness to requests for medication, toileting, bathing, and information as essential aspects of their hospital stay and quality of care. It is critical for staff to respond to patients' calls promptly as it is demonstrating thoughtfulness and respectfulness in the delivery of care. In their study of patients' concerns about quality, Sofaer et al. (2005) explained that patients would change hospitals if responsiveness to their needs were not met. The Joint Commission and CMS identified staff responsiveness as a significant patient customer service domain. Patients just are not satisfied with "good" health care experience. They are seeking excellent customer service (Levin & Hopkins, 2014) and nursing care. In support, Lin (1996) and Charmel and Frampton (2008) argued that for decades nurses have advocated for patient centered care as the core of nursing. Lin argued that the practice of nursing is patient driven and patient centered. The authors recommended a practice design that not only treat patients but “comfort, engage and empower” them as partners in their care (p.80).

With mandates of the ACA and the hospital reimbursement linked to patient satisfaction, the need to deliver care that results in a quality experience is paramount to healthcare leaders (Berkowitz, 2016). In this present media-led environment, consumers are more motivated to get involved with their healthcare issues. Patient-centered care is accepted by healthcare leaders who have identified patient experience and satisfaction as important domains to the future of the healthcare industry. The healthcare industry

regulatory agencies, policymakers, and research bodies adopted the IOM's (2001) six guiding principles that embody quality care. According to the IOM (2001), nurses should be responsiveness and respectful to individual patient preferences, needs, and values. Specifically, evidence base practice indicate nurses should consider patient preferences to ensure that patient values are incorporated into clinical decision-making. To be respectful is an example of patient-centered care, and respect can establish mutual trust and understanding (Burman, Robinson, & Hart, 2013; Melnyk, Fineout-Overholt, Stilwell & Williamson, 2010; Thompson, 2017). Researchers agreed that patients would benefit from safe, reliable, and more responsive care if a model of patient-centeredness is adopted (Bertakis & Azari, 2011; Dean & Street, 2013; Epstein & Street, 2011; Flag, 2015; Reuben & Tinetti, 2012; Stellefson, Dipnarine, & Stopka, 2013; Ubel, Scherr, & Fagerlin, 2016).

Several studies revealed nursing actions are fundamental to the patient care experience and ultimate patient satisfaction (Aiken et al., 2002; Ford, 2010; Manary et al., 2013). Patients rate the nurse-patient relationship as an important aspect of their health care experience. They also value safety, respect, explainable instructions, quality service, effective communication, and staff responsiveness (Hall & Press, 1996; Hayes & Tyler-Ball, 2007; Lachman, 2012; McCabe, 2004; Mitchell, Lavenberg, Trotta, & Umscheid, 2014; Morse, Havens, & Wilson, 1997; Sheldon et al., 2009). Staff responsiveness is a metric of HCAHPS and serves as a catalyst to maintain overall safety in the patient care environment. Responding to patients' needs and requests is essential to a successful nurse-patient relationship and provide opportunities for active patient

involvement and communication about plan of care (Ford, 2010). According to Ford (2010) patients acknowledge reliability, responsiveness, and effective communication which leads to improvement in patient's satisfaction.

Tzeng and Yin (2009) explored nurses' perspectives on call light and response time. The investigator found 52% of staff perceived call light as a safety issue, and almost 82% saw it as meaningful. However, nearly 44% reported that answering call lights prevented them from performing important duties. Additionally, Nelson and Staffileno (2017) investigated improving patient experience on staff responsiveness to call lights and found that creating a culture of shared responsibility can influence how staff respond to call lights. In support of Nelson and Staffileno (2017), a hospital survey found there is set of identifiable activities that should occur at specific times. Specific times to impact call light use. Timely nurse activities were statistically linked with patient decreased use of the call lights. Further, positive reports of decreased patient fall, and increased patient satisfaction were demonstrated (Meade, Bursell, & Ketselsen, 2006).

Conversely, Van Handel, and Krug (1994) found patient satisfaction scores for an orthopedic floor indicated dissatisfied patients because of slow response to call lights. Cardoso and Martin (2003) explained the relationship between a speedy call bell response and patient satisfaction consist of different parts. Aspects of the complexity of call bell response vary from equipment to critical thinking and decrease response. The researchers added that some patients from the study did not use the call bell but responded to the questions anyway. Reluctance to use call bell, the researchers explained, may show preconceived thoughts about nurses' responses. Finally, the researchers found no

significant relationship between patient satisfaction and response time that exceeds three minutes (Cardoso & Martin, 2003). Response to call bell is of great significance to the nurse-sensitive outcome. It is also an important priority for patients as they see quick response time as evidence of nurse's presence, safety, and trust in nursing care (Roszell, Jones, Lynn, 2009; Woodward, 2009).

### **Quality of Care**

With increasing health care costs and the challenges of social media, there is a need for healthcare organizations to distinguish themselves. Most hospitals strive to differentiate from others by recognizing patients' experience and satisfaction as important gauges on how health services are delivered, and how patients measure the quality of care. To better serve patients, hospitals have taken steps to evaluate individual survey results to assess patient's perception of satisfaction and quality care. Healthcare organizations are encouraged to compare the quality of service they deliver by using patient's satisfaction scores from surveys given by different governmental, public, and private agencies. One such agency is the CMS, which uses the HCAHPS survey to measure hospital in-patient satisfaction (Jha et al., 2008; Weech-Maldonado, Hall, Bryant, Jenkins, & Elliott, 2012).

Manary et al. (2013) argued that despite the widespread uses of these survey tools to measure patients' perception of quality care, there are uncertain agreements as to their credibility to capture delivery of care. For example, Brooks-Carthon et al. (2011) revealed racially ethnic patients getting care in hospitals with a more significant portion of African American patients were having much lower satisfaction rate with their care.

The researchers also found that there was a relationship between nursing attitude, institutional establishment, quality of care, and patient satisfaction (Brooks-Carthon et al., 2011). Similarly, Hasnain-Wynia et al. (2010) used the Hospital Quality Alliance (HQA) survey that measured hospital performances and reported hospitals that served a more substantial number of minority patients scored lower on quality scales than hospitals attending to non-minority patients.

Otani, Kurz, and Barney (2004) explored how nursing care and other hospital features such as admitting procedure, hospital culture, treatment of family and friends, medical care and discharge instruction impact patient satisfaction and intent to return. Among the various features, nursing care surpassed the others as the most valuable to increase patient satisfaction and return intent. Other researchers showed how socio-demographics, hospital characteristics, and gender differences influenced the measurement of patient satisfaction with nursing care (Elliot et al., 2012). As the first national study on gender and hospital experiences as measured by HCAHPS scores, the results showed that women had less satisfaction with nursing care than men. In addition, the research concluded that women had different expectations for hospital staff behaviors and had less favorable reactions with nurses than physicians (Elliott et al., 2012).

In contrast, Chumbler, Otani, Desai, Hermann and Kurz (2016) explained that compared to their male equivalents older female patients generally convey more satisfaction with nursing care. A reasonable explanation for the contradiction with these two studies that utilized HCAHPS as measuring tools is that Chumbler et al. (2016) used women over 65 years or older and Elliott et al. (2012) used females from 18 years or

older at time of admission. Some studies have shown age to be a persistent factor in patient satisfaction and are linked to patient satisfaction scores. Several studies have demonstrated that younger generations are linked with lower satisfaction scores, and older age groups are linked to higher satisfaction scores (Chumbler et al., 2016; DeVoe, Wallace, Fryer, 2009; Thiedke, 2007). Despite the consistency of dissatisfaction among younger patients, Foss (2002) and Elliott et al. (2012) explained similar findings had females showing negative satisfaction experience with nursing care. Even though different hospital characteristics and patient experiences played a role in the dissatisfaction of women, nursing communication was identified as the major contributing factor (Elliott et al., 2012).

### **Nurse Communication**

Communication is one of the essential tools in the nurse-patient relationship. Finke, and others (2008) wrote that effective nurse-patient communication is an important operational tool in delivering patient care. The nurse-patient relationship requires interaction and can be complicated and unsafe when discussion of any kind is challenged. An essential aspect of the nurse-patient relationship is communication. Interactive connection between nurses and patients is indispensable to delivering and accepting care (Finke et al., 2008). Evaluations of literature highlighted patients' dissatisfaction with nursing care because of poor, ineffective, or incongruent communication by nurses (Lang, 2012; Stimpfel, Sloane, & Aiken, 2012; Wittenberg-Lyles, Goldsmith, & Ferrell, 2012). According to Merkouris, Ifantopoulos, Lanara and Lemonidou (1999), communication is a mechanism for organizational structure.

Communication is part of the formal structure and process of improving patient satisfaction. Improving patient satisfaction requires a caring organizational model to guide all hospital departments in service of the patient.

Radtke (2013) conducted a pilot study on a medical/surgical care unit to improve patient satisfaction with nurse communication by using standardized shift report. The goal of the study was to increase the unit's patient-nurse communication score of 76% to 90%. The study utilized Peplau's theory of Interpersonal Relations and explained that nurse-patient relationship is therapeutic. Additionally, Lewin's Change theory based on unfreezing, moving, and refreezing was used for the change aspect of the study. After three months of continued bedside shift reporting, the researchers concluded the unit's patient satisfaction increased to 87.6%; this was an increase of over 12% over the previous six months. Although the goal of 90% was not met, the increase shows that practice change made a difference, and affected communication as it related to patient satisfaction (Radtke, 2013).

### **Effects of Language Barrier on Health Care**

Caring for the patient is complicated, and the quality can be determined by the communication between provider and patient. A provider-patient relationship connection is important and how it is perceived by the patient can result in favorable or unfavorable outcomes. Being able to communicate in one's native language allows patients to express their concerns more comfortably and makes for safe and quality healthcare encounters (Karlner, Kim, Meltzer, & Auerbach, 2010). Researchers have shown providers' physical approach affects communication more negatively with minority patients than

non-minority patients (Diette & Rand, 2007; Penner et al., 2009). Because communication between provider and patient is essential, it is important to focus on its impact during the healthcare encounter.

In a study of poor urban Hispanic parents and children with asthma, Clark et al. (1990) found mothers who could speak Spanish during the healthcare encounter communicated freely about their children's asthma and their use of home remedies. Further evidence revealed that Spanish-speaking mothers managed their children's asthma attacks much better by having regular communication with providers, because they had some control over how they communicated their concerns. In contrast, Claudio and Stingone (2009) conducted a study using 1,847 randomly-selected Latino children to determine if language barriers affected the level of asthma management and quality of care. The study showed that the prevalence of asthma was higher in Hispanic households that spoke predominately Spanish compared to Hispanic families that spoke English. Furthermore, the Spanish-speaking parents reported they were less likely to have the care they needed on weekends and lacked communicating with their child's physician about treatment plan (Claudio & Stingone, 2009). Because communication is essential in the healthcare relationship, it is fundamental to understand and be understood, and not merely to express information. Therefore, patients' plan of care must include interventions that are perceived by patients to be individualized and favorable to them while meeting their physical and psychosocial needs (Diette & Rand, 2007; McCabe, 2004).



Borrell-Carrió et al. (2004) explained how a biopsychosocial model deals with the philosophy of disease and illness, focusing on how suffering, disease, and illness are affected by the way society functions. The biopsychosocial model is a clinical care and practical clinical guide for clinicians. It helps the clinician to identify and understand that the patient's subjective experience is a necessary component of the care process. It helps to reach the right diagnosis, to get positive health outcomes, and to deliver benevolent care. For instance, the practice of intersubjective relations between clinician and patient allows the patient latitude to express fears and encourages the clinician to question about a patient's expectations, and at the same time allows the clinician to be humanized. Furthermore, a relationship in which patient and clinician support an environment for equal representation (Borrell-Carrió et al., 2004) will foster effective communication and better health outcomes (Diette & Rand, 2007).

With the extension of ACA to most Americans, there will be many thousands of Limited English Proficient (LEP) persons seeking health services. Eventually, some people will receive health care insurance for the first time and find it difficult to navigate the system, while others may not have received care for the first time and still find it difficult. Studies have found that LEP patients have higher rates of complications, higher rates of admission and more extended hospitalization, (Betancourt & McGrory, 2014; Gallagher, Porter, Monuteaux, & Stack, 2013; Karliner, Kim, Meltzer, & Auerbach, 2010; Lindholm, Hargraves, Ferguson, & Reed, 2012; Rogers, Delgado, & Simon, 2004). The new CMS model and HCAHPS reimbursement policy and VBP allow health organizations to increase their competitive edge and financial incentives. Expanding

quality of care for LEP patients may strengthen the CMS model while improving the hospital's advantage within the community while improving patient satisfaction. Since HCAHPS is the primary measuring tool for patient satisfaction with ACA, hospitals are strengthening their efforts to utilize HCAHPS with LEP patients (Cyracom, 2016).

Limited English Proficient (LEP) patients most likely rate hospitals below adequate compared to groups speaking English. The National Center for Biotechnology Information (NCBI) revealed patients with LEP are nine times more likely to have trouble understanding a medical scenario, four times more likely to misunderstand medication labels, and four times more likely to have an adverse reaction to medications. The HCAHPS survey questions include provider/patient communication with a significant emphasis on whether the patient felt heard, understood, and respected, and whether the patient could follow their provider's instructions. Despite the provision of some level of language services in most hospitals, HCAHPS results for LEP patients suggest they do not sense the quality of expertise is always being met (Cyracom, 2016; Wilson, Chen, Grumbach, Wang, & Fernandez, 2005).

### **Medication Education**

Over several decades, changes in healthcare policies driven by social, legal, economic and demographic issues have emphasized the fundamental purpose of the nurse in the patient's health care goals, such as medication education (Fincham, 2013; Grant & Greene, 2012; Marcus, 2014; Mason, 2011). Researchers have identified changes in patients' demographics as getting increasingly older than the previous generation. Compared to previous decades, diseases are growing more complex; patients are sicker,

and yet they are spending less time in hospitals. There are many tiers to medication administration, and patients rely on nurses to educate and assess patient comprehension in order to decrease the risk of medication error (Bailey, Engel, Luescher, & Taylor, 2011). A new medication is a significant patient satisfaction indicator as a quality measure on the HCAHPS survey (Gillam, Gillam, Casler, & Curcio, 2015). Gillam et al. (2015) found that when educating patients on new medications, it is significant to use medication reminders and medication information together. The researchers saw substantial changes in errors when used together and were more effective than when used separately.

Overall, education of the patient as a healthcare customer is worthwhile to the healthcare professional-patient relationship. Patient education plays a vital role in positive patient outcomes and benefits the nurse in the role of caregiver. Knowledgeable nurses who can answer healthcare questions are one of the patients' many expectations (Oermann & Templin, 2000). Despite many changes carried out by the body of nursing and the overall healthcare system, traditional viewpoints still exist that allow nurses to question practice methods that they deem inappropriate and lacking in compassion (Melnechenko, 2003).

### **Patients' Expectations of Care**

The rise of social media entices customers to do their own research before seeking health care. Patients rely on word-of-mouth and hospitals' advertisements to make healthcare decisions. These dynamics allow prospective customers to develop expectations about the care they should receive (Lee & Kvasny, 2014). Because nursing

care is such an important factor in patient satisfaction, it is imperative that nurses make themselves aware of patients' expectations (Jackson & Kroenke, 2001; Reck, 2013). John (1992) and Singh (1990) viewed patient satisfaction as an attitude that is influenced by patient expectations. An expectation of nursing care is defined merely as what the patients expect or desire from the nurse who is caring for them. According to Hunt (1999), patients expect nurses to be vigilant, capable, experienced, and skilled technically, while giving personalized care. Reck (2013) argued that previous studies on patient expectations benefitted from tools that focused on patients' "ideal" views of nursing care at "ideal" hospitals, instead of focusing on receipt of the actual care in a real hospital (p. 111). Further, he suggested the importance of patient satisfaction with nursing care should be based on actual hospital experience and not an imaginary idealized scenario.

### **Patients' Perceptions of Care**

The role of patients' perception is based on a different theoretical framework from which patient satisfaction is a gauge for quality care. Shim (2010) described CHC as a theory that fundamentally embodies patient-centered care, influenced by the mutual respect and responsiveness of the other, a relationship between patient and caregiver. This theoretical framework has been used significantly in areas of healthcare to explain the significance of equity in healthcare, nurse-patient interaction, and human behavior (Shim, 2010). Shim's (2010) new concept of CHC is based on a range of cultural principles nurtured by patients and health professionals. The theory proposes that clinical skills are essential, but to meet patients' expectation of quality care and consequently

patient satisfaction, the professional must display proficient practical and emotional skills during interactions (Dean & Street, 2014).

Alternatively, Kutney-Lee et al. (2009; 2015) supported the argument that variations in patient and nurse outcomes are linked to hospital Magnet designation. Magnet hospitals demonstrated increased patient satisfaction with care, plus nurse satisfaction with staffing ratio and positive work environment. Additionally, Magnet-hospitals are linked to lower mortality rates and nurses with advanced education (McHugh et al., 2013; Needleman & Hassmiller, 2009; Perez-Pena, 2012). Reports of patient satisfaction are significant to the hospital comparison HCAHPS survey results. Patients' HCAHPS survey scores give hospitals understanding of patients' hospital experience and satisfaction with overall quality of care. Meanwhile, prospective patients can compare hospitals based on results from the public, and not the organizations' leaders.

Patients' assessment of healthcare quality has powerful and notable impacts on patient satisfaction and affects patient trust for the healthcare system and providers. Therefore, the patient's understanding of healthcare services will impact how quality is perceived. Though patients' assessment of the experience may fluctuate, an individual seeking care interprets the healthcare encounter and experience different from the healthcare professional. Molzahn and Northcott (1989) reported that deviation in any aspect of perception reflects the quality of care. Therefore, as the provider, it is significant to deliver care that positively influences a patient's perception.

Healthcare delivery and distribution are done by multiple disciplines; however, nurses are the most visible group and spend a larger proportion of time with patients. Because nurses are at the forefront of the healthcare system, interactions with patients are inevitable. This visibility requires nurses to portray a sense of commitment and understanding of patients' physical, social, and psychological differences that make up patients' values, beliefs, and desires as individuals or as cultural groups. The absence of assurance and understanding can lead to conflicting ideas and result in perceived negative results.

According to Aiken and colleagues (2008), adequate nurse staffing levels, quality working conditions, quality support by nurse managers and administrations, and quality nurse-physician relationship have been linked to decreased mortality and overall patient satisfaction in the hospital. Aiken et al. (2008) studied over 200,000 surgical patients and over 10,000 nurses from 168 Pennsylvania hospitals. Their goal was to examine whether the culture of nurse practice affected nurse and patient outcomes. The results from this study were mostly positive for nurses and patients, but the authors recommended improvement to the care environment. In contrast, a study to examine patient satisfaction while being cared for by foreign-educated nurses working in the United States gave mixed results (Mazurenko & Menachemi, 2016). The use of foreign-educated nurses had a significantly negative association with six patient satisfaction measures. Hospitals with foreign-educated nurses scored lower on nurse communication, communication about administered medication, communication about home recovery instructions, and physician communication. Overall, hospitals using foreign-educated nurses scored lower

on overall satisfaction and willingness to recommend hospital (Mazurenko & Menachemi, 2016). This study addressed one of the gaps in the literature by using research material from esteemed researchers to educate future nurses on the importance of nurse/patient communication and patient perception of care as a whole. Reviews of nursing literature have highlighted the importance of nurse autonomy and nursing communication skills and the need for nurses to be engaged and skillfully interactive when caring for patients from the admission to discharge process. Patient's expectations often begin and end with nurses, and thus satisfaction of care rests on the compassion and educational preparation of the individual nurse.

### **Summary and Conclusions**

In this chapter, I reviewed the literature in support of this study. Patients view staff responsiveness to requests for medication, toileting, bathing and information as important aspects of their hospital stay and quality of care. Not only is it critical for staff to respond to patients' calls, it is important to do so in a timely manner, using effective communication and strive to meet patients' expectations. Major themes emphasized in this chapter were theoretical foundation, nurse's educational preparation, patient's expectation and Magnet-designation.

## Chapter 3: Research Method

### **Introduction**

The purpose of this quantitative study was to determine whether patient satisfaction with specific nursing care has a relationship to hospital Magnet designation. Specifically, I explored whether Magnet designation is related to patient satisfaction with nursing care (i.e., active nursing communication, effective pain management, timely responsiveness, explanation of medicines, and willingness to recommend the hospital). Therefore, I performed descriptive secondary data analysis to test my hypotheses.

Using expectancy disconfirmation theory (Oliver, 1967) integrated with the cultural health capital model (Shim, 2010), I analyzed the relationship between Magnet designation and patient satisfaction scores. In expectancy disconfirmation theory, patients are primarily confirming or disconfirming how well the hospital delivered care based on the comparison between consumer service expectations and actual performance delivery (Lankton & McKnight, 2012). Additionally, Kupner and Bond (2012) explained that consumer satisfaction is experience-based because the experience is evaluated against the consumer expectation. Furthermore, applying the theory, the patient seeking nursing care desires the experience to be centered around preferences related to individual values and needs.

The chapter includes an overview of, and rationale for, the methodology I used in the study to advance nursing knowledge relating to patient satisfaction with nursing care. Specifically, the population and sampling procedures, instrumentation and operationalization of variables, data collection procedures, and data analysis plan are



discussed. Data collection started after my proposal was approved by the dissertation committee and Walden University's Institutional Review Board (IRB).

### **Research Design and Rationale**

In order to explore the relationship between Magnet designation and patient satisfaction, I used a quantitative design in which I performed a descriptive secondary data analysis. This design was suitable to examine the relationship between Magnet designation and patient satisfaction because there was no manipulation of variables. The independent variable explained what I believed is the presumed cause of the relationship between two variables (see Hinote & Wasserman, 2017). The independent variable for this study was Magnet designation. The dependent variable describes the effect the researcher hopes to explain (Hinote & Wasserman, 2017). The dependent variables encompassed five areas of patient satisfaction: (a) effective nurse communication, (b) effective pain management, (c) timely response, (d) explanation of medicines, and (e) willingness to recommend).

### **Methodology**

#### **Population**

The research term *population* describes a set of elements that have specific characteristics defined by the sampling frame as set by the researcher (Ingham-Broomfield, 2014; Polit & Hungler, 2013; Visser, Krosnick, & Lavrakas, 2000). My study's targeted population of hospitals met the CMS-required level of 300 or more HCAHPS responses for the reporting year. According to CMS, hospitals reporting fewer than 300 responses per year may not meet the standard criteria set to have accurate

findings that can be generalizable to the greater population (Quality Assurance Guidelines, 2018). Furthermore, smaller hospitals with fewer than 300 responses in a 12-month period are encouraged to survey all eligible discharges to have as many surveys completed as possible (Quality Assurance Guidelines, 2015). The sampling frame for my study included all hospitals in the United States that met the research inclusion criteria (acute inpatient hospitals with at least the CMS-required 300 HCAHPS surveys within the study period) and exclusion criteria (hospital focusing on children's or specialty care).

The target populations for this study consisted of Magnet-designated and non-Magnet hospitals located in the United States that provide only acute inpatient care. Magnet-designated hospitals in the United States are listed on the ANCC website. Hospitals that had Magnet approval by December 2015 were suitable for this research. Designation prior to December 2015 would mean that hospitals had Magnet status for at least one quarter or longer establishing that they had met Magnet standards before the study period (April 1, 2015 to March 31, 2016). Non-Magnet hospitals were identified as hospitals that did not meet ANCC criteria or did not undergo the Magnet process. In 2017, Magnet designation was assigned to 445 hospitals across all 50 states and the District of Columbia (AANC, 2018; Kutney-Lee et al., 2015). Based on the ANCC database, 353 of the 445 Magnet-designated hospitals had met the desired criteria set for this research (see Appendix B for the list of hospitals). As of 2017 there were currently a total of 5,564 hospitals registered in the United States (AHA, 2018). Subtracting 353 Magnet hospitals from the total number of registered hospitals (5,534) resulted in 5,181

non-Magnet hospitals as the population from which the study's sample of non-Magnet hospitals was drawn.

### **Sampling and Sampling Procedures**

Quantitative researchers use sampling to predict or estimate outcomes based on a sample of the larger population and to make generalizations about individuals from whom data were not collected (Endacott & Botti, 2005). To generalize, the researcher should apply measures that ensure that the sample is representative of the target population (Endacott & Botti, 2005; Houser, 2007; Visser et al., 2000). In the current study, I investigated two populations which required the use of different sampling procedures.

Given the small number of Magnet-designated hospitals in the United States that met the study criteria, I decided to include the entire population based on the total population sampling method (see Etikan, Musa, & Alkassim, 2016). Total population sampling is a type of purposive sampling in which the entire population of interest is included in the study; this sampling technique is generally implemented for relatively small populations (Etikan et al., 2016). However, the non-Magnet hospital population was comparatively large, and therefore a random sample was selected.

To account for possible geographic influences on patient satisfaction (e.g., Jha et al., 2008; Lyu, Wick, Housman, Freischlag, & Makary, 2013; Saha et al., 1999), I used a stratified random sampling technique by state to select non-Magnet hospitals in the United States. Stratified random sampling is a technique in which strata or groups within a population are identified, and then elements or units within a stratum are randomly

sampled (Neyman, 1934). Researchers use stratified random sampling to obtain a sample size for each stratum with respect to its proportion to the overall total population (Neyman, 1934). In this study, the non-Magnet hospitals' sample size by state matched Magnet hospitals' sample size by state. Specifically, in my sampling the total number of non-Magnet hospitals in each state matches the total number Magnet-designated hospitals, in each state. For example, if Florida had 10 Magnet-designated hospitals, then 10 non-Magnet hospitals was randomly sampled from all non-Magnet hospitals in Florida meeting study inclusion and exclusion criteria.

Sampling method. Sampling methods can be characterized as either probability or non-probability (Shorten & Moorley, 2014). Stratified random sampling is a probability-based sampling method and gives the object a known chance of being selected. The total population sampling is a non-probability sampling method and gives the possibility of not knowing that there is a chance of being chosen (Doherty, 1994; Field, Pruchno, Bewley, Lemay, & Levinsky, 2006). By using stratified sampling, hospitals in the non-Magnet sample should be representative of all non-Magnet, acute inpatient hospitals in the United States with Hospital Compare scores. Within each state, every hospital that satisfies the inclusion and exclusion criteria have an equal chance of being selected in the sample. The use of random sampling is to guard against bias in the sampling process (Field, Pruchno, Bewley, Lemay, & Levinsky, 2006). In order to obtain the stratified random sample of non-Magnet hospitals, there are four steps. Specifically, these four steps include: 1) Identify list of Magnet hospitals meeting study criteria; 2) Identify list of all hospitals with Hospital Compare scores during study period removing Magnet hospitals; 3)

Randomly sampling non-Magnet hospitals by same state (or bordering state when necessary); and 4) verify non-Magnet hospitals meet study criteria. If a non-Magnet hospital does not meet study criteria, a different non-Magnet hospital were randomly selected. The random sampling was done using a public website (True Random Number Services, 2018).

**Power analysis.** For this study, G\*Power was used to determine the appropriate sample size required to achieve 80% power for hypotheses testing (G\*Power; Faul, Erdfelder, Lang, & Buchner, 2007). To calculate the required sample size, using a priori power analysis, the following information was necessary: test type, effect size, selected alpha, desired power level, and degrees of freedom. A moderate effect size was chosen based on previous research demonstrating consistent moderate to large effects of Magnet status on patient satisfaction (Berkowitz, 2016; Kelly, Mathew, & Aiken, 2011; Stimpfel, et al., 2016). An acceptable, and commonly used, power level of 80% was selected (Prajapati, Dunne, & Armstong, 2010; Shintani, 2011). Using a moderate effect size, the power analysis indicated a total sample size of 133 hospitals would be required based on the following parameters: test type = chi-square contingency table; effect size ( $w$ ) = .30; alpha level = .05; desired power level = 80%; and degrees of freedom = 4. As stated previously, given the small number of Magnet-designated hospitals in the United States that meet study criteria, the entire population of Magnet-designated hospitals was included (353 hospitals); the same number of non-Magnet hospitals were selected (353 hospitals). In total, the anticipated sample was estimated to include 706 hospitals, which

exceeded the minimum sample size estimate required by the power analysis to achieve at least 80% power to find a significant relationship between the study variables.

### **Archival Data Collection**

I used secondary data measuring patient satisfaction which is publicly reported on the Hospital Compare website maintained by CMS. Hospitals' patient satisfaction data are stored and available to the public for download from the CMS Hospital Compare website without approval or consent. However, electronic documentation of support was requested and received with authorization from CMS personnel. This dataset, the Hospital Compare Excel file from April 1, 2015, through March 31, 2016, was downloaded after IRB approval. As previously mentioned, Magnet-designated and non-Magnet hospitals were identified as meeting study inclusion and exclusion criteria through several public websites (AHA, 2016; ANCC, 2016; CMS, 2016).

### **Instrumentation and Operationalization of Constructs**

I quantified the various components of patient satisfaction using the HCAHPS surveys. Magnet designation of hospitals was identified from the ANCC website.

**HCAHPS Survey.** The HCAHPS, formerly known as CAHPS®, is a standardized survey instrument given to patients after 48 hours through six weeks following discharge from an inpatient stay. CMS is responsible for guiding the administration of the survey, and publicly reports the results of each hospital (HCAHPS Fact Sheet, 2017).

As the first nationally and publicly standardized survey, it is noteworthy to highlight that HCAHPS is designed to measure patient's perception of their hospital care. This survey allows the nation's hospitals to compare their organizations to others so that

patients can make well-informed choices using fair comparable information and responses from other patients. Preceding the public release of HCAHPS, CMS and other affiliated organizations launched a detailed and multifaceted systematic process that included public input, literature reviews, cognitive review, stakeholder input, three-state pilot tests, consumer testing, and psychometric analyses (HCAHPS Fact Sheet, 2015). For example, the public was allowed three opportunities to participate and comment on publications on the HCAHPS websites. The CMS/HCAHPS website received and responded to over 1,000 public comments. CMS joined with AHRQ in 2002 to begin developing and testing the initial version of the HCAHPS.

In 2005, the National Quality Forum (NQF), a coalition organization that represents state, federal, and private health organizations, recognized the HCAHPS as a viable survey to measure patients' standard perception of satisfaction (AHRQ, 2015). The Office of Management and Budget (OMB) acknowledged and gave their approval for HCAHPS public reporting. In 2006, the HCAHPS survey administration was started and had its first public report documented in 2008. Originally, the HCAHPS had 27 items, and in 2013 CMS added five more new items bringing, it to 32 items (HCAHPS Fact Sheet, 2015). The five additional items included: three questions related to a change in post-hospital care, one question about hospital emergency room admission, and one question about mental and psychological health. Furthermore, in 2015, CMS added Star Ratings for the HCAHPS to the Hospital Compare website. Star Rating is a concise version of each measure of the HCAHPS feature, written to make it easier for patients to identify the standard quality of healthcare (HCAHPS Fact Sheet, 2015). Currently, the

HCAHPS survey, its practice and procedure, and generated results are all available to the public on their website. As of July 2017, CMS publicly reported 4,315 hospitals' HCAHPS scores based on more than 1.3 million patient surveys (HCAHPS Fact Sheet, 2017).

*Instrumentation of HCAHPS.* The HCAHPS survey is made up of 32 questions. Survey questions cover key aspects of the patient hospital experience with staff and environment. A random sample of inpatients discharged within 48 hours to six weeks of hospitalization from CMS/HCAHPS participating facilities are subject to participate in the survey process by mail, mail with telephone follow-up, phone, or interactive voice response (IVR). Patients who request privacy upon admission, patients discharged to hospice, and incarcerated patients are not subjected to being surveyed.

With endorsement from the NQF in 2008 the HCAHPS became the first publicly reported and published data survey system of patients' perception of their hospital experience. The questionnaire is available in English, Spanish, Russian, Chinese, Portuguese, and Vietnamese (HCAHPS Fact Sheet, 2015). I used a quantitative design approach to perform descriptive secondary data analysis to explore the relationship between the Magnet designation and patients' satisfaction measured by HCAHPS scores.

As a survey instrument, the HCAHPS was appropriate for this study. It is commonly used in studies examining the role that Magnet designation has on patient experience and patient satisfaction scores (Andersen, Rice, & Kominski, 2011; McHugh & Stimpfel, 2012; Russell, 2010; Smith, 2014; Tinkham, 2014). Additionally, all hospitals that participate in federally-funded health care programs have a mandatory



requirement to participate in the HCAHPS survey process whereas any hospital not involved with federally-funded healthcare programs have voluntary participation (HCAHPS Fact Sheet, 2015). As a publicly reported instrument, authorization is not needed to access or use the HCAHPS surveys. HCAHPS is guided by three broad and vital goals. First, as a survey instrument, it gathers data of patients' perceptions of care, thus giving consumers actual and significant information to compare hospitals on topics that are important to them. Second, hospitals have the opportunity to improve quality of care with the lure of incentives. Third, publicly reporting quality of care survey results increase healthcare accountability and improves hospital transparency in return for the public trust (HCAHPS Fact Sheet, 2015).

Given the advanced use of patient satisfaction in assessing hospital quality of care, research has been growing on how to measure patient experience. Several researchers have suggested that specific populations, such as minority and Medicare recipients as patients in hospitals, are connected to lower satisfaction rates (Brooks-Carthon et al., 2011; Goldstein et al. 2009; Weech-Maldonado et al., 2012). Others pointed out that there are institutional distinctions, which produce higher satisfaction rates such as smaller hospitals, non-profit position, and decrease patients with Medicaid (Jha et al., 2008). In addition, recent literature has highlighted the increased interest in the role nursing care plays in patient care experience and their HCAHPS survey results. Researchers have even ventured to suggest that nursing care was more predictive of HCAHPS scores than any other characteristics of the hospital experience such as environment, physician care, and meal service (Otani et al., 2010; Wolosin et al., 2012).

**Operationalization. of variables.** Of the 32 HCAHPS survey questions, only a subset is publicly available; additionally, consumer-friendly star ratings, calculated by HCAHPS, are available by patient satisfaction domain (e.g., satisfaction with nurse communication). HCAHPS scores are reported to the public utilizing a five-star rating scale, which is used to make information more accessible to comprehend and allow for consumers to quickly identify excellent healthcare quality. According to CMS, the star rating is calculated from the top-box score, which is the highest ranked responses on the survey (i.e., "Always", "9 or 10", or "Yes"; HCAHPS Fact Sheet, 2015). Specifically, this study focused on patient satisfaction items related to, nurse communication star rating, responsiveness star rating, pain management star rating, medication explanation star rating, and willingness to recommend hospital star rating.

The analysis was conducted on secondary data gathered from the publicly-reported HCAHPS, relating to patient satisfaction with their hospital environment and the nursing care they received during their hospitalization, available on the Hospital Compare database. The study sample size consisted of 353 Magnet-designated and 353 non-Magnet hospitals from all regions of the United States were evaluated for a total of 706 hospitals. Hospitals for this study met the following criteria: 1) Received Magnet-designation as of December 2015 (for Magnet-designated hospitals only); 2) Not specified as Children's only; and 3) Not have a specialty designation (such as Cancer, Orthopedic, Women Services or Rehabilitation only).

The research was not limited to only patient satisfaction survey participation from Medicare and Medicaid insurance participants, but, was open to data from patient

HCAHPS surveys listed on the Hospital Compare website. For discharged patients to participate in the HCAHPS survey, the hospitals must have, however, met specific criteria established by the Quality Assurance Guidelines of the survey. Respondents surveyed were randomly chosen from specific hospitals from which patients were admitted. Interviewers conducting HCAHPS survey must be specially trained individuals employed by participating hospitals and CMS through a third-party vendor system. Surveys must have been done within two days and up to no more than six weeks of patients' discharge from hospitals. The selected date for data availability was from April 1st, 2015 to March 31st, 2016.

The CMS acknowledged that patients' responses to the survey could be affected by administration mode. Burroughs, Waterman, Cira, Desikan, and Dunagan (2001) randomly sampled participants who received a standardized satisfaction survey by either telephone or mail 10 to 14 days after discharge. Results indicated that telephone replies were substantially more favorable than mail replies for all four samples. After the researchers adjusted for demographics and other differences, telephone replies still showed positive ratings. Similarly, De Vries, Elliot, Hepner, Keller, and Hays (2005) studied over 20,000 participants by mail and telephone suggested that telephone participants were more likely than mail participants to rate their care positively. The tool used to gather information for patient satisfaction is a questionnaire designed by HCAHPS with Quality Assurance Guidelines. Telephone and mail are standard modes of collecting data from participants by participating hospitals. De Vries and colleagues

(2005) suggested the administration method be standardized or prudently modify for differences.

For this study, all HCAHPS survey responses were used, including mail, telephone and IVR to examine the relationships between Magnet-designated status and patients' satisfaction with care. From these survey responses, patients' perception to determine if hospital status was a factor in how responses were chosen was scaled. No data manipulation or transformation was conducted to maintain the integrity of the research design and respondents' data.

**Variables.** In this study, the independent variable was Magnet-designation status. This was a categorical variable consisting of two groups: (a) Magnet-designated hospitals and (b) non-Magnet hospitals. The five dependent variables related to patient satisfaction were

- effective nurse communication,
- effective pain management,
- timely responsiveness to care,
- explanation of medicines, and
- willingness to recommend hospital.

The dependent variables were measured using a five-star rating scale. The quantitative design for this study permitted me to explore if there were relationships between Magnet-designation status and patient satisfaction with nursing care (i.e., nurses' effective communication, effective pain management, provision of timely care, explanation of medicines, and patient willingness to recommend the hospital).

The data collection instrument for this quantitative study was the HCAHPS survey, which was developed by CMS and the AHQR. Data for the survey was collected by CMS and hospitals third-party vendors to assess patients' hospital experience and gauge their satisfaction (Jha et al., 2008). For this study, the items related to nursing communication, the responsiveness of staff, timely care, explanation of medicines, and willingness to recommend hospital were used to assess patients' satisfaction.

### **Data Analysis Plan**

I used the Statistical Package for the Social Sciences (SPSS) software to conduct chi-square test of independence analyses. When testing whether a relationship or association exists between two categorical variables, measured on a nominal or ordinal scale, the chi-square test of independence is an appropriate inferential statistical test (Hole, 2006). Specifically, chi-square is quantitatively used to investigate whether distributions of categorical variables have a relationship with one another, or whether variables are consistent with expectations (Hole, 2006).

Secondary data from a national public website was used in which permission to access the necessary archives was not needed. Participants' consent was not necessary as the data represent archival, aggregated hospital HCAHPS scores based on patient satisfaction interviews, phone calls or mail surveys from April 1st, 2015 to March 31, 2016. Furthermore, participants' identifying information (e.g., name, address, age, and their health care problems) are not available on the public website and were not necessary for purposes of this study. In the case that any identifying information was found in the

data collection process, it would be eliminated to protect the participants and maintain the integrity of the study; however, no identifying information was discovered.

Rudestam and Newton (2007) wrote that questionnaires, behavioral observations, extended interviews, and archival data are all useful sources of data collection instruments. Patton (2002) added that during an interview, the quality of data collected depends on the interviewer. It allows the interviewer to move into the participant's viewpoint, applying meaning to his or her thoughts. Because this study used secondary data, the researcher did not conduct any interviews. However, data were drawn from standard fixed response item questionnaires to gather previously collected and archived responses. Patton (2002) explained that standard fixed surveys are closed and limiting in nature. Such data is suitable for this research as it is difficult to manipulate the questions to achieve favorable or unfavorable responses.

The non-experimental, quantitative approach was favored to collect the necessary information from relevant public data. Only existing HCAHPS questionnaires from April 1st, 2015 to March 31st, 2016 were reviewed, and no interaction occurred between participants and the researcher. Quantitative data analysis approach is about assessing the statistical relationships between and among two or more variable (Hall, 2010; Hopkins, 2008). Secondary data was collected from three public data (AHA, Hospital Compare and HCHAPS) sources, and the original HCAHPS survey records to explore and understand the patients' perception of their nursing care and to further investigate the relationships, if any, between Magnet-designated and non-Magnet hospital patients' HCAHPS satisfaction survey scores.

Research questions and hypotheses. The purpose of this study was to explore if a relationship existed between Magnet-designation status and patient satisfaction related to nursing care. The research questions for this study examined hospital Magnet-designation and patient satisfaction with nursing care based on receiving effective communication, receiving effective pain management, and receiving timely care, timely responsiveness and willingness to recommend.

RQ1: Is there a relationship between Magnet-designation and patient satisfaction with receiving effective communication?

H1<sub>0</sub>: There is no relationship between Magnet-designation and patient satisfaction with receiving effective communication.

H1<sub>A</sub>: There is a relationship between Magnet-designation and patient satisfaction with receiving effective communication.

RQ2. Is there a relationship between Magnet-designation and patient satisfaction with receiving effective pain management?

H2<sub>0</sub>. There is no relationship between Magnet-designation and patient satisfaction with receiving effective pain management.

H2<sub>A</sub>: There is a relationship between Magnet-designation and patient satisfaction with receiving effective pain management.

RQ3: Is there a relationship between Magnet-designation and patient satisfaction with responsiveness of care?

H3<sub>0</sub>: There is no relationship between Magnet-designation and patient satisfaction with responsiveness of care.

H3<sub>A</sub>: There is a relationship between Magnet-designation and patient satisfaction with responsiveness of care.

RQ4: Is there a relationship between Magnet-designation and patient satisfaction with explanation of medicine?

H4<sub>0</sub>: There is no relationship between Magnet-designation and patient satisfaction with explanation of medicine.

H4<sub>A</sub>: There is a relationship between Magnet-designation and patient satisfaction with explanation of medicine.

RQ5: Is there a relationship between Magnet-designation and patient willingness to recommend the hospital to friends and family?

H5<sub>0</sub>: There is no relationship between Magnet-designation and patient willingness to recommend the hospital to friends and family.

H5<sub>A</sub>: There is a relationship between Magnet-designation and patient willingness to recommend the hospital to friends and family.

### **Threats to Validity**

This study had several threats to validity related to the data collection. The sample was drawn from secondary data posted on the public database of the CMS website. It is important to have accuracy of data collection to maintain the integrity and trustworthiness of this research. Instrumentation is one threat as the interviewer must maintain strict fidelity to the script. This ensures that the respondent completes the questionnaire according to the instructed process. Selection of subjects is another threat that can create threats to internal validity. Biases can occur and lead to selection of certain groups.



Randomization of participants can counter this bias. To guard against these threats, random sampling was used according to sample guidelines stated before (Campbell & Stanley, 1963). As for instrumentation, CMS has guidelines to guard against such threats.

CMS has built-in adjustments in the calculation to avoid any effects of survey mode response bias (HCAHPS Fact Sheet, 2015). De Vries et al. (2005) suggested that telephone responses to the HCAHPS survey increase the likelihood that responses are more advantageous for greater than half the items examined. To explain this effect, Burroughs et al. (2001) compared parallel random samples from inpatient, outpatient care/treatment, outpatient surgery, and emergency services. Burroughs and associates (2001) randomly sampled participants who received a standardized satisfaction survey by either telephone or mail 10 to 14 days after discharge. Results indicated that telephone replies were substantially more certain than mail replies for all four samples. After the researchers adjusted for demographics and other differences, telephone replies still showed positive ratings.

### **Ethical Procedures**

The goal of this research was to answer the research questions and to further public policy therefore ensuring accuracy is paramount. However, HCAHPS questionnaires are collected through structured interviews and conducted by educated personnel. Even though the interviewers are trained to ask the HCAHPS questions, the questions could be answered by any household member. As a registered nurse and educator, I am aware that because of my professional experiences with patients of different races and ethnic backgrounds, there could likely be ethical concerns or biased

behavior in retrieving the data. Using the data does not give me direct contact with the patient, therefore, it was unlikely for data manipulation to occur during this study.

Additionally, it is not possible to separate an individual's data from the publicly available subset of aggregate data to be used in this study's analysis. After IRB approval was obtained data collection was commenced. The data was publicly available on Hospital Compare website and access with minimal difficulty.

### **Summary**

Hospitals selected to be in this study fulfilled characteristics such as location and hospital type. The study used secondary data gathered from public websites for participating hospitals. This research identified chosen hospitals as Magnet-designated and non-Magnet. Hospitals that have not completed a minimum of 300 surveys were not eligible to participate this study. Chapter 4 explains the data collection and analysis results. The chapter further describes reported statistics, evaluation of statistical assumptions, and other conclusive statistical results.

## Chapter 4: Results

### Introduction

The primary purpose of this research was to explore whether there was any relationship between patient satisfaction with specific nursing care behaviors (as per HCAHPS scores) and Magnet-designated hospitals nationally. In today's healthcare market, improving patient satisfaction with nursing care as measured by hospital HCAHPS scores is essential to the survival of U.S. hospitals. Many hospitals in the nation have adopted the consumer satisfaction service model and identified critical components of patient satisfaction and service quality improvements as important hospital functions (Tam, 2004). Similarly, patients see themselves as consumers and receivers of health services. Patients' response to the care they receive shapes their perceptions of their hospital experiences and is then translated to satisfaction (Chen et al., 2014). The link between reimbursement and HCAHPS star ratings provide the incentives for prioritization of patient perception of care (Isaac et al., 2010; Jha et al., 2008; Lasater, Germack, Small, & McHugh, 2016).

Specifically, I examined the relationship between HCAHPS patient satisfaction scores and Magnet designation. The independent variable was Magnet-designation, which is a categorical variable consisting of two groups: (a) Magnet-designated hospitals and (b) non-Magnet hospitals. The dependent variables were patient satisfaction with (a) effective communication, (b) effective pain management, (c) timely response, (d) explanation of medicines, and (e) willingness to recommend hospital. The dependent variables were measured using a 5-star rating scale. CMS creates composite star ratings

(e.g., effective nurse communication) from several patient satisfaction questions based on a 4-point Likert-type response scale ranging from (1) *never*, (2) *sometimes*, (3) *usually*, and (4) *always* (CMS, 2018).

### **Research Questions and Hypotheses**

RQ1: Is there a relationship between Magnet designation and patient satisfaction with receiving effective communication?

$H_01$ : There is no relationship between Magnet designation and patient satisfaction with receiving effective communication.

$H_A1$ : There is a relationship between Magnet designation and patient satisfaction with receiving effective communication.

RQ2: Is there a relationship between Magnet designation and patient satisfaction with receiving effective pain management?

$H_02$ . There is no relationship between Magnet designation and patient satisfaction with receiving effective pain management.

$H_A2$ : There is a relationship between Magnet designation and patient satisfaction with receiving effective pain management.

RQ3: Is there a relationship between Magnet designation and patient satisfaction with responsiveness of care?

$H_03$ : There is no relationship between Magnet designation and patient satisfaction with responsiveness of care.

$H_A3$ : There is a relationship between Magnet designation and patient satisfaction with responsiveness of care.

RQ4: Is there a relationship between Magnet designation and patient satisfaction with explanation of medicine?

$H_04$ : There is no relationship between Magnet designation and patient satisfaction with explanation of medicine.

$H_A4$ : There is a relationship between Magnet designation and patient satisfaction with explanation of medicine.

RQ5: Is there a relationship between Magnet designation and patient willingness to recommend the hospital to friends and family?

$H_05$ : There is no relationship between Magnet designation and patient willingness to recommend the hospital to friends and family.

$H_A5$ : There is a relationship between Magnet designation and patient willingness to recommend the hospital to friends and family.

In Chapter 4, I review the data collection and data analysis methods, including how the data were organized; describe the sample used for statistical analysis; and present the results. Information on how statistical assumptions were evaluated and the results of hypothesis tests are also provided. The chapter ends with a summary section.

### **Data Collection**

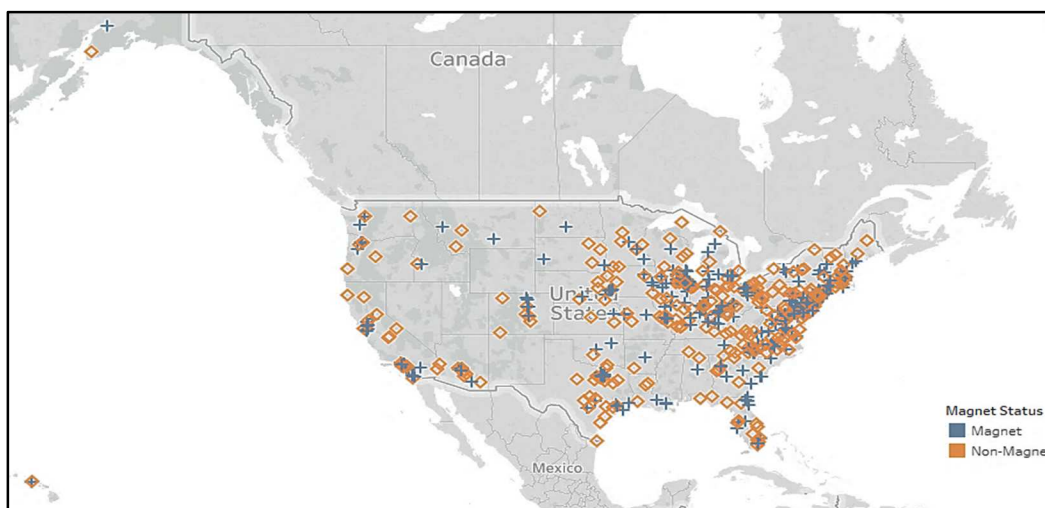
To examine the relationship between Magnet designation and patient satisfaction, I collected data from three data sources. The secondary data measuring patient satisfaction, following discharge from an inpatient hospital stay, were collected using the HCAHPS survey administered by CMS between April 1, 2015, and March 31, 2016. The identification of Magnet-designated and non-Magnet hospitals was based on a publicly

reported list of all Magnet-designated hospitals current through March 31, 2015, which I obtained from the ANCC website (ANCC, 2015), and a publicly available list of all hospitals in the American Hospital Association Directory (AHD, 2016). I examined the HCAHPS patient satisfaction scores of patients treated in Magnet-designated and non-Magnet hospitals. Further, the data from the ANCC, AHA, AHD, and Hospital Compare are complete and accurate according to the patient and organizational guidelines and characteristics on the databases. I considered the data from these databases valid because they were obtained from a reliable instrument, the HCAHPS survey (HCAHPS Quality Assurance Guidelines, 2018; CMS, 2016b).

There were an equal number of hospitals from Magnet ( $N = 317$ ) and non-Magnet hospitals ( $N = 317$ ) in the sample. Magnet hospitals had, on average, 1725.61 completed surveys ( $SD = 1353.66$ ) compared to non-Magnet hospitals' average of 769.15 completed surveys ( $SD = 764.77$ ). Given the skewed distributions of the completed surveys for both Magnet and non-Magnet hospitals, it is important to recognize the wide variation within each group. Specifically, Magnet hospitals had a median of 1,308 surveys (interquartile range = 773 – 2,290) completed and average of approximately 1,725 surveys. Similarly, non-Magnet hospitals had a median of 520 surveys (interquartile range = 305- 916) completed and an average of approximately 769 surveys. All hospitals were required to meet a minimum of 100 completed surveys to be included in the analysis. Although Magnet-designated hospitals have a higher average number of completed surveys compared to the non-Magnet hospitals in my study, the response rate was similar between

the Magnet-designated ( $M = 27.68\%$ ,  $SD = 5.38\%$ ) and non-Magnet hospitals ( $M = 27.99\%$ ,  $SD = 8.18\%$ ) sampled for this study.

The sampling methods used in the study underscore the generalizability of the samples to the larger hospital populations. For instance, the population sampling method used for the Magnet-designated hospital sample includes all Magnet-designated hospitals meeting study criteria; therefore, it is largely representative of the Magnet-designated hospital population. Additionally, the stratified random sampling used for the non-Magnet hospital sample guards against bias in the sampling and selection process. Specifically, a stratified random sample was selected from the full list of non-Magnet hospitals that met the aforementioned study criteria with stratification based on the number of Magnet-designated hospitals by state. The use of random sampling theoretically should improve the generalizability of the non-Magnet sample to the population of non-Magnet hospitals. It is important to note that most Magnet-designated hospitals were located in the mid-West and East Coast regions of the U. S., and therefore a higher proportion of the Magnet-designated and non-Magnet hospital data from those regions are represented. Using Tableau visualization software (Tableau, 2018) and hospital addresses from the HCAHPS, Figure 1 displays the distribution of hospitals by Magnet-designation and state. Also, four states were completely unrepresented in the current study (i.e., Mississippi, Nevada, New Mexico, Utah) due to an absence of Magnet-designated hospitals that met study criteria.



*Figure 1.* Distribution of sampled Magnet and non-Magnet hospitals across the United States.

As of December 2017, the largest number of Magnet-designated hospitals are found in the Midwest, with Illinois leading the way. Illinois has 43 Magnet-designated hospitals, of which 27 hospitals met study criteria and were sampled (8.5% of final Magnet-designated sample). California and Texas are tied for the second most sampled Magnet-designated hospitals that met study criteria with 21 Magnet-designated hospitals each (6.6% of final Magnet-designated sample). Ohio and Pennsylvania are tied with 19 Magnet-designated hospitals each that met study criteria and were sampled (6% of total Magnet-designated hospitals each that met study criteria and were sampled (6% of total Magnet-designated sample)). New York and Virginia follow with a tie for 18 sampled Magnet-designated hospitals that met study criteria (5.6%). See Table 1 for the complete display of frequencies by Magnet-designation and state.



Table 1

*Count of Hospitals by Magnet Designation and State*

State	Magnet hospitals	Non-Magnet hospitals	Total hospitals
AK	1	1	2
AL	1	1	2
AR	1	1	2
AZ	8	8	16
CA	21	21	42
CO	6	6	12
CT	4	4	8
DC	1	1	2
DE	2	2	4
FL	13	13	26
GA	5	5	10
HI	1	1	2
IA	7	7	14
ID	1	1	2
IL	27	27	54
IN	11	11	22
KS	2	2	4
KY	4	4	8
LA	3	3	6
MA	6	6	12
MD	7	7	14
ME	2	2	4
MI	8	8	16
MN	3	3	6
MO	4	4	8
MT	2	2	4
NC	16	16	32
ND	1	1	2
NE	5	5	10
NH	3	3	6
NJ	20	20	40
NY	18	18	36
OH	19	19	38
OK	2	2	4
OR	4	4	8
PA	19	19	38
RI	2	2	4
SC	2	2	4
SD	3	3	6
TN	1	1	2
TX	21	21	42
VA	18	18	36
VT	2	2	4
WA	2	2	4
WI	7	7	14
WV	1	1	2
<b>Total hospitals</b>	<b>317</b>	<b>317</b>	<b>634</b>

## Results

### Descriptive Statistics

Given the data protection and restrictions put in place by CMS, access to demographic variables at the hospital level is not publicly available. However, CMS reports on the aggregate level across all hospitals that complete the HCAHPS survey. While this study deals with the relationship between Magnet-designation and patient experience according to their response rates on HCAHPS it is important to note that the experience relating to care occurred prior to the survey response. Additionally, some researchers suggested if the patient has a negative experience, he or she is less likely to respond to a survey compared to an individual with a positive experience (Mazor, Clauser, Field, Yood, & Gurwitz, 2002; Siegrist, 2013).

Since hospital inpatients may reflect the population in which they are located, and previous research has suggested demographics (e.g., gender, race) affect communication, delivery of care, and perceptions of care, it is essential to look at hospital regions. The current study explored if any relationships exist between Magnet-designation and patient satisfaction to specific nursing care. However, Elliot et al. (2012) reported that women seek more health care services compared to men; additionally, women report more negative experiences than men in HCAHPS responses. Similarly, a three-state pilot study analysis done by HCAHPS found women tend to rate care more negatively than men (HCAHPS, 2003). While non-Hispanic White Americans seek more health care than minority groups (including Hispanic Americans), African Americans and Asian Americans report more negative care compared to non-Hispanic White Americans

(Goldstein et al., 2015). Further, compared to the hospitals normally frequented by minorities, Goldstein et al. (2015) revealed that White Americans tend to seek care at hospitals that deliver better patient experiences to all patients as indicated by HCAHPS composite measures.

### **Preliminary Data Analysis**

Power analyses can be used in an effort to prevent Type I (i.e., false positive) and Type II errors (i.e., false negative; Rothman, 2010). More specifically, G\*Power was used to determine the appropriate sample size required to achieve 80% power for hypotheses testing (Faul et al., 2007). To calculate the required sample size, an *a priori* power analysis was previously conducted based on the following information: test type = chi-square contingency table; effect size ( $w$ ) = .30; alpha level = .05; desired power level = 80%; and degrees of freedom = 4. The power analysis indicated a total sample size of 133 hospitals would be required to achieve 80% power. Given the small population size of Magnet-designated hospitals, population sampling was used. Therefore, the stratified random sample of non-Magnet hospitals would need to equal the number of Magnet-designated hospitals and meet the minimum required sample size of 133 hospitals. Of the 426 hospitals designated as Magnet on the ANCC website as of April 1<sup>st</sup>, 2015, there were 109 hospitals that did not meet CMS criteria for HCAHPS scores or that did not meet my study criteria (Campaign for Action, 2017). Specifically, CMS indicates that data from hospitals with less than 100 surveys completed or 50% response rate are considered “unsuitable” or “lack completeness,” respectively. Results from these hospitals are based on a shorter time period than required and fewer than 100 patients

completed the HCAHPS survey. The HCAHPS scores were used with caution, as the number of surveys may be too low to reliably assess hospital performance. Further, there were discrepancies in the data collection process.

These hospitals were thus removed from the current data. In addition to the criteria set by HCAHPS, hospitals must have met additional criteria for my study; specifically, hospitals must be non-specialty, adult-only, and located in the United States. Therefore, 36 of the 353 Magnet designated hospitals were removed for unsuitable data leaving a total number of 317 Magnet-designated hospitals. The final samples included 317 Magnet-designated hospitals and 317 non-Magnet hospitals. Data from the final samples were examined for quality prior to statistical analysis. Additionally, using G\* Power, post hoc power analysis revealed chi square test of independence analysis reached 100% power to detect significant relationships between Magnet designation and patient satisfaction.

### **Chi-Square Analysis**

In this quantitative study, chi-square test of independence was done using International Business Machine Corporation (IBM) Statistical Package for the Social Sciences (SPSS) software (Version 20). The chi-square test of independence, also called Pearson's chi-square test or the chi-square test of association, is used to discover if there is a relationship between two categorical variables (Laerd Statistics, 2012). Chi-square was used to investigate the research questions and to determine whether each of the five patient satisfaction measures are significantly related to Magnet-designation of hospitals. Particularly, the *Cramer's V*, the effect size index for the chi-square, indicates the

magnitude of the relationship between patient satisfaction and Magnet-designation (Cohen, 1992).

Chi-square test of independence requires the data meet two assumptions: (1) independence, and (b) (2) categorical scale of data. Magnet-designated and non-Magnet categories are mutually exclusive for this date range, and therefore the data meet the assumption of independent groups. Theoretically, patient satisfaction star ratings are mutually exclusive ordinal categories based on a calculation of top-box or highest rank response option on the HCAHPS. Practically, potential overlap between responses is possible given that the ordinal measurement scale was used compared to a continuous measurement scale such as interval or ratio.

. Further, Magnet-designation and the patient satisfaction star-ratings are measured on nominal and ordinal scales, respectively, each meeting the categorical data requirement.

## **Findings**

Research Question 1. Is there a relationship between Magnet-designation and patient satisfaction with receiving effective communication?

Null Hypothesis 1 ( $H_{10}$ ). There is no relationship between Magnet-designation and patient satisfaction with receiving effective communication.

Hypothesis 1 was tested using Pearson chi-square test of independence to determine whether effective communication was related to Magnet-designation. To explore this relationship, the dependent variable was the overall patient satisfaction composite score and the independent variable was Magnet-designation. The null

hypothesis was rejected only if Magnet- designation showed significant relationship to effective communication at a level of  $p < 0.05$ . Magnet-designation was significantly related to effective nurse communication,  $\chi^2(4, N = 634) = 54.91, p < .001, Cramer's V = .294$ . The statistical relationships between patient satisfaction with specific nursing care demonstrated the practical impact of hospitals meaningfulness among patients. According to the analysis, Magnet-designation shares a small-to-moderate relationship with nurse communication. Therefore, this study rejects the null hypothesis that there is no relationship between Magnet-designation and patient satisfaction with receiving effective communication.

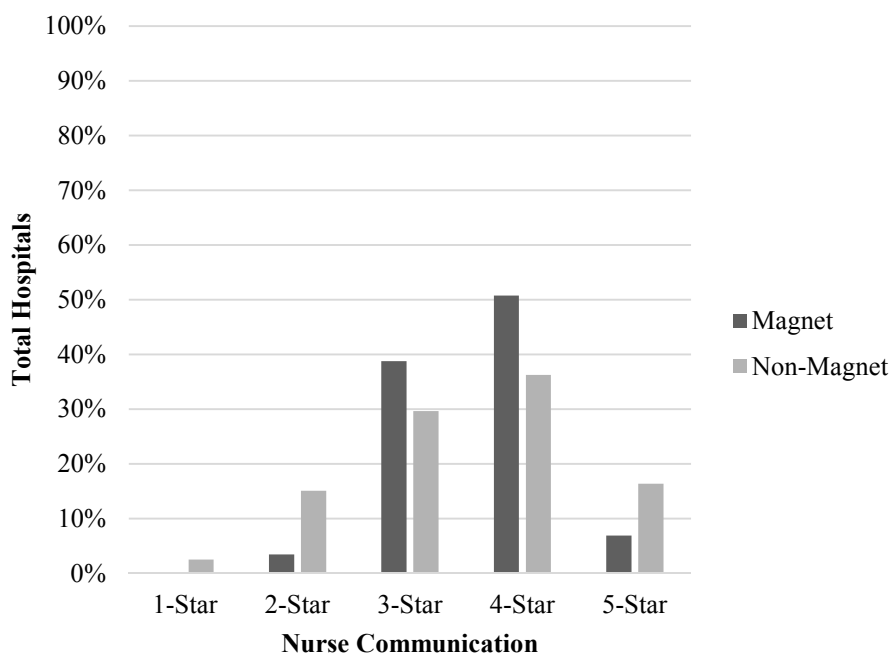
Based on the survey analysis results below in Table 2, 16% of non-Magnet hospitals ( $n = 52$ ) received 5-star ratings for patient satisfaction with effective nurse communication compared to 7% of Magnet-designated hospitals ( $n = 22$ ). Overall, Magnet-designated hospitals appear to have more consistency of 3-star and 4-star ratings; conversely, non-Magnet hospitals tend to receive more normally distributed star ratings with higher volume in the tails (i.e., 1- star, 2-star, and 5 star) compared to Magnet-designated. Surprisingly, though small, non-Magnet hospitals have more 5-star ratings showing some polarization on the high end. A higher percentage of Magnet-designated hospitals are ranked at the 4-star ratings (51%) compared to non-Magnet hospitals (36%). Figure 2 displays the relationship between Magnet-designation and nurse communication.

Table 2

*Relationship Between Magnet Designation and Nurse Communication*

Star rating	Magnet		Non-Magnet		Total
	<i>n</i>	%	<i>n</i>	%	
1	0	0%	8	3%	8
2	11	3%	48	15%	59
3	123	39%	94	30%	217
4	161	51%	115	36%	276
5	22	7%	52	16%	74
Total	317	100%	317	100%	634

*Note.* Percentage totals may not add to 100% due to rounding.



*Figure 2.* Distribution of Magnet and non-Magnet hospitals by patient satisfaction with nurse communication.

*Research Question 2. Is there a relationship between Magnet-designation and patient satisfaction with receiving effective pain management?*

**Null Hypothesis 2 (H2<sub>0</sub>).** There is no relationship between Magnet-designation and patient satisfaction with receiving effective pain management.

Hypothesis 2 was tested using Pearson chi-square test of independence to determine whether receiving effective pain management was related to Magnet-designation. To explore this relationship, the dependent variable was overall patient satisfaction composite score and the independent variable was Magnet-designation. The null hypothesis was rejected only if Magnet-designation shows significant relationship to patient satisfaction with receiving effective pain management at a level of  $p < 0.05$ . Based on the survey analysis below, results in Table 3, non-Magnet hospitals looked polarized with a higher proportion of 5-star ratings with patient satisfaction in receiving effective pain management compared to Magnet-designated hospitals.

Table 3

*Relationship Between Magnet Designation and Pain Management*

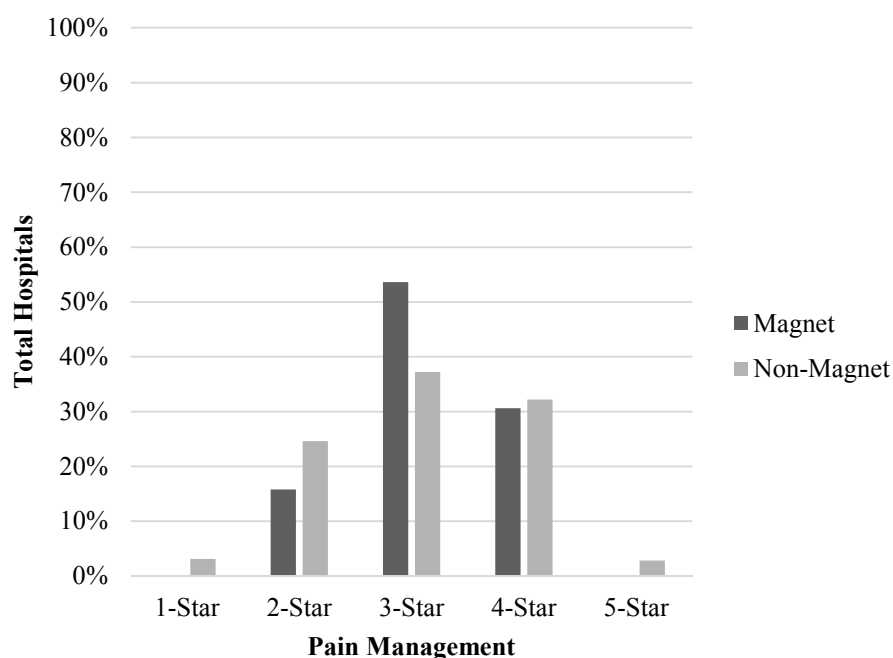
Star rating	Magnet		Non-Magnet		Total
	<i>n</i>	%	<i>n</i>	%	
1	0	0%	10	3%	10
2	50	16%	78	25%	128
3	170	54%	118	37%	288
4	97	31%	102	32%	199
5	0	0%	9	3%	9
Total	317	100%	317	100%	634

*Note.* Percentage totals may not add to 100% due to rounding.



Non-Magnet hospitals received 5-star ratings for effective pain management while Magnet-designated hospitals had zero 5-star ratings. On the other hand, patient satisfaction results showed Magnet-designated hospitals consistently scored better in 3- and 4-stars ratings. Five-star ratings are considered a sign of superior health care and higher scores could indicate more patients are satisfied with how reports of pain are measured and effectively managed during hospitalization. Additionally, non-Magnet hospitals underperformed Magnet-designated hospitals in the 1 and 2-star ratings. Therefore, these findings showed Magnet- designation shares a small relationship with effective pain management, ( $\chi^2(4, N = 634) = 34.64, p < .001, Cramer's V = .234$ ).

Figure 3 displays the relationship between Magnet-designation and pain management.



*Figure 3.* Distribution of Magnet and non-Magnet hospitals by patient satisfaction with pain management

*Research Question 3. Is there a relationship between Magnet-designation and patient satisfaction with responsiveness of care?*

**Null Hypothesis 3 (H3<sub>0</sub>).** There is no relationship between Magnet-designation and patient satisfaction with responsiveness of care.

Hypothesis 3 was tested using Pearson chi-square test of independence to determine whether patient satisfaction with responsiveness of care was related to Magnet-designation. To explore this relationship, the dependent variable was overall patient satisfaction composite score and the independent variable was Magnet-designation. The null hypothesis was rejected only if Magnet-designation showed significant relationship to patient satisfaction with responsiveness of care at a level of  $p < 0.05$ . Based on the survey analysis below, results in Table 4 showed patient satisfaction with responsiveness of care scored a higher proportion in Magnet-designated hospitals compared to non-Magnet hospitals with 3-star and 4-star ratings.

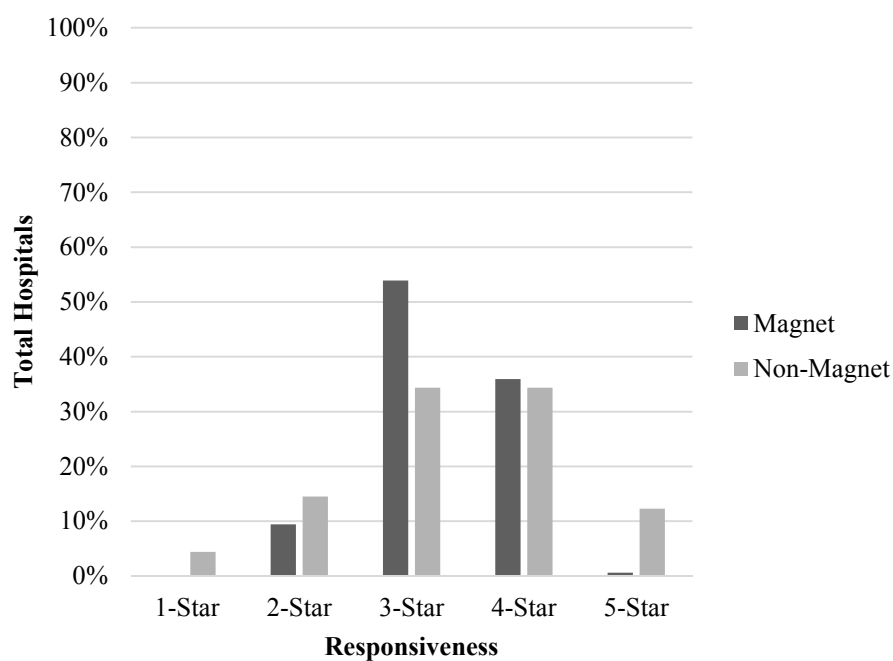
Table 4

*Relationship Between Magnet Designation and Staff Responsiveness*

Star rating	Magnet		Non-Magnet		Total
	<i>n</i>	%	<i>n</i>	%	
1	0	0%	14	4%	14
2	30	9%	46	15%	76
3	171	54%	109	34%	280
4	114	36%	109	34%	223
5	2	1%	39	12%	41
Total	317	100%	317	100%	634

*Note.* Percentage totals may not add to 100% due to rounding.

Based on the survey results in Table 4, Magnet-designation shared a moderate relationship with patient satisfaction regarding staff responsiveness, ( $\chi^2(4, N = 634) = 64.60, p < .001, Cramer's V = .319$ ). However, more non-Magnet hospitals rated as 5-star compared to Magnet-designated hospitals. According to the analysis, Magnet-designated hospitals, consistently register a greater proportion in 3-stars and 4-stars and lower proportion in 5-star ratings compared to non-Magnet hospitals. As for 2-stars ratings non-Magnet hospitals outperformed Magnet-designated with a score of 15% compared to 9%. These findings showed Magnet-designation was significantly related to patient satisfaction with staff responsiveness. Figure 4 displays the relationship between Magnet-designation and staff responsiveness.



*Figure 4.* Distribution of Magnet and non-Magnet hospitals by patient aatisfaction with staff responsiveness.

*Research Question 4: Is there a relationship between Magnet-designation and patient satisfaction with explanation of medicine?*

**Null Hypothesis 4 (H4<sub>0</sub>).** There is no relationship between Magnet-designation and patient satisfaction with explanation of medicine.

Hypothesis 4 was tested using Pearson chi-square test of independence to determine whether patient satisfaction with explanation of medicine was related to Magnet-designation. To explore this relationship, the dependent variable was overall patient satisfaction composite score and the independent variable was Magnet-designation. The null hypothesis was rejected only if Magnet-designation shows significant relationship to patient satisfaction with explanation of medicine at a level of  $p < 0.05$ . Based on the survey analysis below, displayed in Table 5, nearly 59% of Magnet-designated hospitals achieved 3-star ratings on patient satisfaction regarding explanation about medication compared to 39% of non-Magnet hospitals.

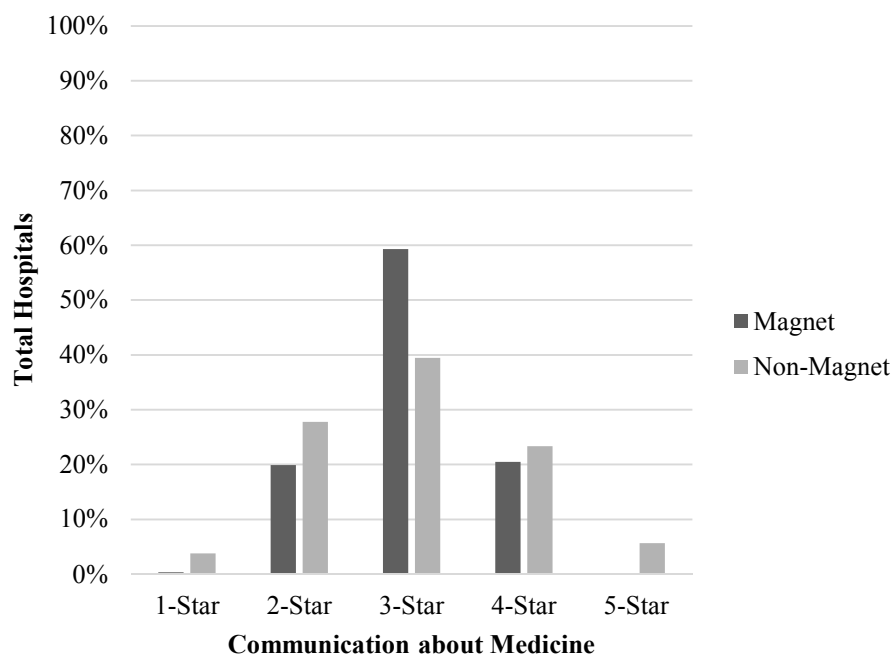
Table 5

*Relationship Between Magnet Designation and Explanation About Medicine*

Star rating	Magnet		Non-Magnet		Total
	<i>n</i>	%	<i>n</i>	%	
1	1	0%	12	4%	13
2	63	20%	88	28%	151
3	188	59%	125	39%	313
4	65	21%	74	23%	139
5	0	0%	18	6%	18
Total	317	100%	317	100%	634

*Note.* Percentage totals may not add to 100% due to rounding.

In comparison, based on the results in illustrated in Table 5, patients cared for by Magnet-designated hospital contributed to less 4-star ratings than patients in non-Magnet hospital in response to satisfaction with explanation about medicines. Again, non-Magnet hospitals are polarized on the high end with 6% of 5-star ratings on explanation about medicines, compared to Magnet-designated hospitals zero percent. However, Magnet-designated hospitals scored a higher proportion of 3 stars than non-Magnet showing Magnet-designated more polarized on the low end of the spectrum. Additionally, the results for explanation about medicine showed non-Magnet hospitals with a slightly higher satisfied rate with more 4-stars than Magnet-designated hospitals. Overall non-Magnet hospitals presented greater showings in all star ratings except 3-stars. However, 100% of Magnet-designated ratings were distributed among 2, 3, and 4- stars. While 90% of non-Magnet ratings were distributed for the same star ratings. The results showed a small effect size, ( $\chi^2(4, N = 634) = 44.71, p < .001, Cramer's V = .266$ ). Figure 5 displays the relationship between Magnet-designation and explanation of medicine.



*Figure 5.* Distribution of Magnet and non-Magnet hospitals by patient satisfaction with explanation about medicine.

*Research Question 5. Is there a relationship between Magnet-designation and patient willingness to recommend the hospital to friends and family?*

**Null Hypotheses 5 (H5<sub>0</sub>).** There is no relationship between Magnet-designation and patient willingness to recommend the hospital to friends and family.

Hypothesis 5 was tested using Pearson chi-square test of independence to determine whether patient willingness to recommend the hospital to friends and family was related to Magnet-designation. To explore this relationship, the dependent variable was overall patient satisfaction composite score and the independent variable was Magnet-designation. The null hypothesis was rejected only if Magnet-designation shows

significant relationship to patient willingness to recommend the hospital to friends and family at a level of  $p < 0.05$ .

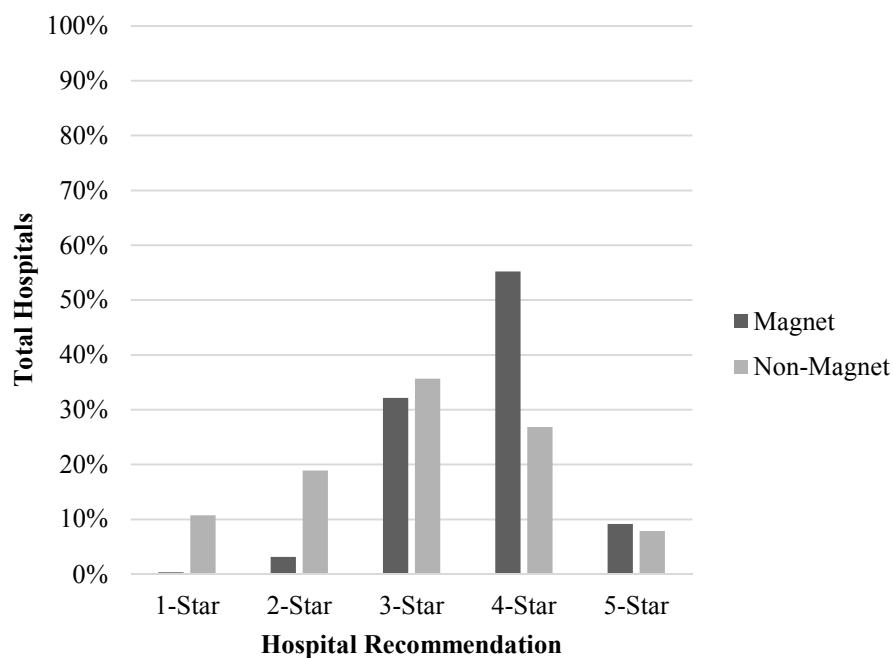
Based on the above survey results in Table 6, Magnet-designation was significantly related to patient satisfaction showing willingness to recommend with a medium effect ( $\chi^2(4, N = 634) = 98.84, p < .001, Cramer's V = .395$ ). The analysis of patient willingness to recommend hospital showed Magnet-designated hospitals scored exceptionally high percentage in the 4-star ratings and one percent higher than non-Magnet in 5-star ratings. This result indicates that there is relationship with Magnet-designation and willingness to recommend hospital to family and friends. Overall, results of this analysis, revealed Magnet-designation hospitals was significantly recommended by patients receiving care in Magnet-designated hospitals. Figure 6 displays a moderate significant relationship between Magnet-designation and hospital recommendation.

Table 6

*Relationship Between Magnet Designation and Hospital Recommendation*

Star rating	Magnet		Non-Magnet		Total
	<i>n</i>	%	<i>n</i>	%	
1	1	0%	34	11%	35
2	10	3%	60	19%	70
3	102	32%	113	36%	215
4	175	55%	85	27%	260
5	29	9%	25	8%	54
Total	317	100%	317	100%	634

*Note.* Percentage totals may not add to 100% due to rounding.



*Figure 6.* Distribution of Magnet and non-Magnet hospitals by patient satisfaction with hospital recommendation.

### Summary

The main purpose of this research was to explore whether there were any significant relationships between patient satisfaction with specific nursing care behaviors per the HCAHPS scores and Magnet-designation nationally. In summary, the analyses supported the hypothesis that Magnet designation significantly relates to patient satisfaction. Overall, the findings indicated Magnet-designated hospitals consistently had a higher proportion of 3-star and 4-star ratings compared to non-Magnet hospitals across the patient satisfaction dimensions. On the contrary, non-Magnet hospitals, tended to be more normally distributed across all five categories of star rating; however, non-Magnet demonstrated a higher proportion of 5- star rating, compared to Magnet designated



hospitals, in patient satisfaction with effective nurse communication, staff responsiveness, and explanation of medicine. Additionally, non-Magnet hospitals demonstrated positive relationships in most categories and outperformed the Magnet hospitals in some. CMS (2018) has previously stated that approximately only 6% of hospitals with completed HCAHPS star ratings achieve a 5-star rating. Interestingly, Magnet-designated hospitals tended to remain around the 3-star and 4-star ratings compared to the random sample of non-Magnet hospitals that tended to have a higher proportion of 5-star ratings; caveated with non-magnet hospital also receiving more 1 and 2-star rating. Specifically, given that all analyses yielded significant results, the relationship between patient satisfaction and Magnet-designation, was supported. Further, the analyses demonstrated small-to-moderate strength relationships between Magnet-designation and patient satisfaction with nursing care behaviors and recommendation of hospital.

In the next chapter, a discussion of the interpretations of research findings in the context of previous research is presented. Furthermore, limitations of the study are identified, implications for positive social change are highlighted, and recommendations of future research are offered. Additionally, I discuss in detail what the theoretical framework revealed and how the findings can be used for future studies pertaining to how factors like patient demographics and nursing culture affect patient satisfaction.

## Chapter 5: Discussion, Conclusions, and Recommendations

### **Introduction**

I conducted this study to determine whether there was a significant relationship between Magnet designation and patient satisfaction with specific nursing care functions according to HCAHPS scores. Patient satisfaction with nursing care has become one of the most discussed subjects in health care. Leaders of U.S. hospitals and other health care institutions are concerned about competition, reputation, and economic loss. With these concerns in mind, hospital leaders have to focus on hiring and maintaining the best people in their respective professions. The people they hired should not only be qualified, but exhibit competency and skill (Hibbard, Stockard, & Tusler, 2005; Staurt, 2014; Teisberg, Porter, & Brown, 1994). Researchers have declared that increased competition improves value over time (Teisberg et al., 1994) . Furthermore, quality improvements lower costs for stakeholders and consumers, which ultimately may lead to patient satisfaction from better outcomes (Fleming, 1991; Rivers & Glover, 2010; Teisberg et al., 1994). Magnet-designated hospitals are known for their focus on quality improvement on patient and nurse outcome.

Magnet-designated hospitals are consistently ranked among the best hospitals (Gerardo, 2017); having such a designation, therefore, increases a hospital's prominence. As several researchers have noted, Magnet designation also promotes the empowerment of nurse governance and excellence in nursing care quality (Armstrong & Laschinger, 2006; Chapman, 2017; Dahinten, Lee, & MacPhee, 2016; Hancock, 2015; Laschinger et al., 2003). Magnet-designated hospitals are linked to lower infection rates (Barnes et al.,

2016) and tend to invest in services that improve patient care quality (Arthurs et al., 2017; Lasater, 2017).

Prior to the introduction of the national HCAHPS survey measurement, individual physicians, hospitals, and clinics sometimes conducted their own patient experience surveys. Some surveys combined patients medical and nursing care experience, while others focused on experience with physicians and hospitals (Bond & Thomas, 1992; Calvin, Becker, Biering, & Grobe, 1999; Goldstein et al., 2000; Oermann, Swank, & Sockrider, 2000; White, 1999). Consequently, surveys assessed patients' perceptions of inpatient care and hospital processes instead of patient satisfaction, results typically precluded adequate analysis, and findings were not easily accessible to the public (Cleary et al., 1991). To assess the patient care experience as it encompasses perception, satisfaction, and participation, the CMS and AHRQ joined together and created HCAHPS as a universal, national survey for the overall U.S. healthcare system in 2006 (CMS, 2019). This universal survey was designed to generate consistent information on hospital care using tools to measure factors of care that the patient values (CMS, 2019). In the current healthcare climate, patient perception has been found to influence patient satisfaction (MacAllister, Zimring, & Ryherd, 2016; Tabler, Scammon, Kim, Farrell, Tomoaia-Cotisel, & Magill, 2014).

Patient satisfaction has become the foremost focus of patient quality measures (Lasater, 2017; Lee, Tu, Chung, & Alter, 2008); Researchers have documented that Magnet hospitals have consistently demonstrated better patient satisfaction scores compared to non-Magnet. The Magnet-designation program operates as a beacon of

excellence in quality patient care and professional nursing practices. Since the inception of the Magnet model in the early 1980s, U.S. hospitals have aspired to achieve qualities and characteristics that set them apart from others. Magnet-designated hospitals have consistently been linked to better patient outcomes, higher rates of nurse job satisfaction, and improved ratings of job environment (Friese et al., 2015; Needleman & Hassmiller, 2009; Ritter, 2011; Stimpfel et al., 2016). However, there are conflicting arguments as to whether patient satisfaction, as measured by the HCAHPS score, is related to Magnet designation or whether other possible characteristics may be involved such as patient and hospital factors (Johnston et al., 2015; Kutney-Lee et al., 2009). This argument created a gap in the literature concerning patient satisfaction as it relates to nursing care and Magnet designation.

Therefore, with this quantitative study, I sought to determine whether Magnet-designation was related to patient satisfaction, specifically as related to these five items from the HCAHPS instrument: (a) effective communication, (b) effective pain management, (c) timely responsiveness to care, (d) explanation of medicines, and (e) willingness to recommend hospital. Overall, the key findings of this research indicated that Magnet designation is significantly related to patient satisfaction. Generally, Magnet designation consistently shared small-to-medium relationships with patient satisfaction relating to specific nursing care behaviors and overall recommendation of hospital. Magnet-designated hospitals tended to have a majority of 3-star and 4-star ratings compared to the stratified random sample of non-Magnet hospitals. In fact, compared to Magnet hospitals, non-Magnet hospitals tended to have a higher proportion of 5-star

ratings, as well as a higher proportion of 1-star and 2-star ratings. Only 6% or so of hospitals with completed HCAHPS star ratings achieve a 5-star rating, according to CMS (2018).

### **Interpretations of the Findings**

There are conflicting arguments as to whether patient satisfaction, as indicated by HCAHPS scores, is related to Magnet designation. Additionally, many nurses question the value of Magnet designation compared to other factors such as patient-ratio (Trinkoff, 2010; Welton, 2014). Given the inconsistent evidence in the literature, additional research was needed to examine the relationship between patient satisfaction with specific nursing care and Magnet designation. I conducted this study to address this gap in the literature. This study increased the body of knowledge as it pertains to identifying the relationship between hospital Magnet-designation and patient satisfaction with specific nursing care as indicated by HCAHPS scores.

Overall, the findings of this study revealed that Magnet designation was significantly related to patient satisfaction with nursing actions in regard to effective communication, pain management, timely response, explanation of medicines, and patients' willingness to recommend hospital. Specifically, a Magnet-designated hospital tended to have consistent 3-and-4-star ratings compared to non-Magnet hospitals, which tended to have a wider distribution on the 5-star rating scale.

The findings of the current study revealed that there were significant relationships between Magnet designation and all specified patient satisfaction measures (effective communication, effective pain management, timely responsiveness to care, explanation

of medicines, and willingness to recommend hospital). Overall, the current findings are largely aligned with previous research demonstrating positive relationships between Magnet designation and patient outcomes (Kelly, McHugh, & Aiken, 2012). Most of the researchers who have examined the relationship between Magnet designation and patient satisfaction have found a beneficial effect (Kutney-Lee et al., 2009; Scott, Sochalski, & Aiken, 1999). My study findings are in line with previous literature establishing that a positive nursing environment, adequate nurse staffing, and transformational leadership contribute to patient satisfaction in Magnet hospitals (Aiken, et al., 2002; Carter, 2013; Johnston et al., 2015; Kutney-Lee et al., 2015; Lasater et al., 2017; Missios, 2017; Wilson et al., 2015).

Patients cared for in Magnet-designated hospitals are significantly more satisfied and are more likely to recommend the hospital (Kutney-Lee et al., 2015; McCaughey, McGhan, Rathert, Williams, & Hearld, 2018). Further, studies show that there is a connection between nurse satisfaction and patient satisfaction. For example, one study explained that when patients sense negativity among staff, they may not know the technicality of the problem, but they sense discontent (McHugh et al., 2015).

Furthermore, previous studies have indicated that dissatisfaction and disrespect among staff can spread and affect nursing care consequently resulting in dissatisfied patients (McHugh et al., 2015; Stimpfel et al., 2016). In a study examining patients' perceptions of nursing care, Schmidt (2003, 2004) confirmed that the nurse has a widespread effect on the patient hospital experience. Satisfied nurses working in positive environments have been found to have patients with high satisfaction rates, when compared to nurses

who work in less positive environments (Stimpfel et al., 2014). Increased level of patient satisfaction and nurse job satisfaction require positive teamwork and support of appropriate leadership. The forces of Magnetism philosophy and nursing practice that benefit nurses and hospitals alike, in turn, produce effective patient outcomes and high patient satisfaction rates (Aiken et al., 2010).

Magnet-designated hospitals attract and retain nurses that believe in delivery of quality nursing services to patients and establish ways to spread best practices in the nursing community (Upenieks, 2003). Patient centered care is one aspect of quality nursing services. Nurses are providing care that incorporate the patient, family, and values that support individual health. Patient centered care empowers the individual and allow him or her to engage in conversations that influence decisions on their health and healthcare (Clay & Parsh, 2016). With the practice of the patient centered care, and relationship in the nursing community, nurses are more invested in patients and families' treatment input. This relationship can lead to positive treatment outcomes and ultimately decrease cost, increase staff satisfaction, and improve patient satisfaction with communication, patient feeling of respect and autonomy (Clay & Parsh, 2016).

Magnet-designation is an important catalyst in developing change processes and transformational leadership to improve patient satisfaction. Studies have linked patient satisfaction with nursing care and reported positive relationships (Smith, 2014; Stimpfel et al., 2016; Wolf, Miller, & Devine, 2003). Patient satisfaction with nursing care is a multifaceted and complex phenomenon that is based on patient's expectation and perception of the delivery of care. Despite the various tools and evidence that have

revealed relationships between patient satisfaction and nursing care, there is no universal method to establish patient's perception and expectation of satisfactory care. However, understanding and anticipating the patient's needs often lie at the foundation of a positive healthcare experience.

Furthermore, it is noted that studies have significantly linked hospitals with satisfied nurses who work in a positive and professional work environment to better patient satisfaction rates through higher HCAHPS scores (Smith, 2014; Stimpfel, et al., 2014). Studies have also established that relationship between hospital improved nurse's work environment and better nurse staffing lead to positive nurse outcome and less burnout despite non-Magnet status (McHugh, Aiken, Eckenhoff, Burns, & Kim, 2016). Prior research indicates that nurses in Magnet-designated hospitals reported higher rates of job satisfaction and lower rates of job turnover compared to non-Magnet hospitals (Drenkard, 2010; Lake, 2002). Interestingly, a study by McHugh et al. (2017) revealed that the Kaiser Permanente model of integrated health system patient and nurse outcomes were comparable to Magnet designated hospitals. Investment in nursing at Kaiser is described as the important factor in its advantage to other non-Magnet hospitals. Even though the benefits of having Magnet-designation may contribute to patient satisfaction there are other influential patients and nurses physical and environmental factors to consider such as gender, race, educational background, and socioeconomic status and work (Applebaum, Fowler, Fielder, Osinubi, & Robson, 2010; Djukic, Kovner, Brewer, Fatehi, Greene, 2014; McFarland, Ornstein, & Holcombe, 2015).



Johnston, Johnston, Bae, Hockenberry, and Avgar (2015) conducted a two-year study on patients' hospital experience and found that there was consistently lower HCAHPS scores from hospitals with more patients of African Americans, Hispanic Americans, Asian Americans, and other race and ethnic backgrounds. African Americans, Asian Americans, and Latino Americans experience more difficulty than White Americans in communicating with physicians and nurses, and feel they are treated with disrespect when receiving health care services (American College of Physicians, 2003). Moreover, minorities experience barriers to care, including lack of insurance or access to Magnet-designated hospitals, and a large portion of minorities feel they would receive better care if they were of a different race or ethnicity (Goldstein et al., 2009).

Compared to the relative amount of positive evidence for Magnet-designation, limited published research exists that contradict the beneficial effect of Magnet-designation on patient and nurse outcomes. Previous researchers have provided evidence to disconfirm Magnet-designation as a champion of excellence in nursing and patient care (e.g. Bachert, 2017; Friese et al., 2015; Lacey et al., 2007; Potera, 2012; Trinkoff & Johantgen, 2010; Wood, 2010). Although my study indicated greater variation in non-Magnet hospitals' ratings, compared to Magnet-designated hospitals which predominantly achieve 3-star and 4-star ratings, my findings offer support that some non-Magnet hospitals can outperform Magnet-designated hospitals. Compared to Magnet designated hospitals, there were more 5-star rated non-Magnet hospitals; however, these results must be interpreted within the context of non-Magnet hospitals' more normally distributed star ratings meaning a higher volume of 1-star and 2-star ratings.

Surprisingly, researchers have found that non-Magnet hospitals have significantly outperformed Magnet hospitals in various metrics such as infection control and post-operative sepsis (Goode, Blegen, Park, Vaughn, & Spetz, 2011). Researchers have documented that there are similar or better nursing work conditions for non-Magnet hospitals compared to Magnet hospitals (Goode et al., 2011; Pizzi, 2010; Trinkoff & Johantgen, 2010). Additionally, Friese and colleagues (2015) illuminated the fact that some Magnet hospitals did not show improvement in patient outcomes three years after receiving Magnet recognition. The implication is that the Magnet program recognizes hospital with a proven record of excellence but does not demonstrate any link with continued improved care results. It should be noted that Friese et al. (2015) expressed concern with their analysis regarding changes in hospital (e.g., mergers/closures), gaps in Magnet-designation, and issues with matching Magnet-designated hospitals to non-Magnet despite attempts to propensity match based on patient and hospital characteristics. Due to the expense of becoming and maintaining Magnet-designation, some hospitals will cease embracing Magnet-designated principles such as improvements in nurse conditions and pay as well as the promotion of research (The Truth About Nursing, 2016). Alternately, some hospitals may start their own program similar, but in place of, the Magnet program (e.g., Pathway to Excellence; Wood, 2010). Concerningly, some nurses have expressed the perspective that Magnet-designation is orchestrated as a promotional advantage rather than sincere efforts for transformation change for improvements in nursing care (The Truth About Nursing, 2016).

## **Findings in Relation to Theoretical Framework**

**Expectancy disconfirmation theory.** Based on the expectancy disconfirmation framework, patients' expectations of hospital care are influenced by lived experience and pre-conceived awareness of expectations from past services. Hospitals with Magnet-designation have set high expectations for excellent nursing care and exemplary quality services which contribute to patient satisfaction (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Wilson, Sleutel, Newcomb, Behan, Walsh, Wells, & Baldwin, 2015). Consistent with current research, Magnet designated hospitals are linked to positive clinical and nursing outcomes. This link is based on nurses that practice autonomy, display leadership and engage in lifelong learning which also result in positive outcomes and lead to higher patient satisfaction rates (Aiken, Clarke, Sloane, Lake & Cheney, 2009; Shepherd & Harris, 2015).

Aside from nursing care, there are institutional characteristics such as bed status, revenue status, or Medicare beneficiaries that also contribute to patient satisfaction (Chen et al., 2014). Besides, Magnet-designated hospitals retain nurses that use effective communication skills, demonstrate prompt responsiveness to patient calls, use effective pain management to deliver pain relief, and practice effective methods to explain medication techniques. Expectancy disconfirmation theory includes the following constructs: 1) expectation, 2) disconfirmation, 3) performance, and 4) satisfaction. Expectations of patients' experience differ among race, culture, and values. Although my study did not focus on race, culture, or values, these are some of the factors that influence patient experience that results in patient satisfaction and survey result rates (Berkowitz,

2016). Based on the expectancy disconfirmation theory, my study findings support the notion that patient satisfaction, with regard to effective nurse communication, pain management, staff responsiveness to care, and explanation of medication during patient care, is theoretically linked to the degree to which nursing performance meets patients' expectations. In line with the expectancy theory, HCAHPS star ratings reflects the relationship between nurse performance and patient satisfaction. Which may be negatively or positively affected by patient's expectations. Expectations play a role in how the patient perceive the healthcare encounter which reflects in the patient's measure of satisfaction of the experience (Linder-Pelz & Struening, 1985). Therefore, when the nurse's performance fulfils the patient's expectations, the patient perceives a positive or negative experience and patient satisfaction may be increased or reduced. Based on investigations of clinical outcome and star ratings, Trzeciak, Gaughan, Bosire, Mazzarelli (2016) found that higher star ratings are related to lower patient complications and better patient experience. On the other hand, MacLean and Shapiro (2016) reported that star ratings have no clinically meaningful performance differences among hospitals as different measures are used according to factors such as hospital size or specialty.

**Cultural health capital theory.** Cultural health capital theory provides another framework to address the organizational norms of hospitals. Organizational factors such as interactional styles, attitudes and behaviors, and cultural skills also provide depth to the complex state of patient satisfaction. The Magnet-designation of hospitals is a branding strategy that acts as an attraction to entice nurses to work for hospitals that advertise improved work environments and better patient clinical outcomes (Shepherd &

Harris, 2015). My findings indicate that patient satisfaction rates are significantly higher in Magnet hospitals than non-Magnet hospitals which may support that Magnet-designation encourages positive patient experiences based on factors of the cultural health capital theory such as dynamics of nursing and patient-centered dialogue of treatment preferences. A patient is willing to recommend the hospital to others when the experience of the hospital culture, attitude, and behaviors of staff and their interactional styles positively affect patient care and experience. The patient expectation is fulfilled, and the organizational performance confirmed, which results in a positive experience and improves patient satisfaction scores.

### **Limitations of the Study**

There were several limitations for this study. Primarily, the most tangible limitation in this study was the secondary nature of the publicly available data provided by CMS. Research with secondary data involve concerns such as study discrepancies in the data collection process that may be relevant to certain variables in the dataset. Further, there could be substantial amount of data that becomes overwhelming to the user and valuable specifics to the study are missed (Cheng & Phillip, 2014; Garmon, 2007). It should be noted that these limitations are not unique to this current study, but rather are innately related to secondary data research. Given this lack of control over the data collection measure and process, the findings should be interpreted in the context of the following limitations.

The data analyzed in this study, such as the HCAHPS scores and identification of Magnet-designation, was retrieved from secondary data sources (ANCC, 2015; Hospital

Compare, 2016). Given the secondary nature of the data, the relationship between patient satisfaction and nursing care behavior was limited to questions provided in the HCAHPS survey. This limitation on the HCAHPS measure questions further restricted my ability to measure the broad areas of nursing behaviors. Due to CMS conducting the HCAHPS survey interview process, I was not directly involved in monitoring fidelity to the data collection protocol established and publicized by CMS. However, CMS clearly identifies and describes their sampling method, interview script, full HCAHPS measures, and additional standardized protocols. Before publicly sharing the data at the hospital aggregate level, CMS validates and identifies potential data validity issues such as hospitals having too few surveys completed or poor response rates. Kukull and Ganquli, 2012) stated that it is essential to consistently pay attention to study sample and generalizability of study results as data inaccuracy can occur if the quality of measuring is compromised. To protect against selection bias or information bias, CMS employs a fair sampling method of randomly surveying patients across the entire United States to provide results that are representative of the American population. Notably, there are some exceptions to which hospitals are included in the HCAHPS. Though mandatory, HCAHPS does not include all hospitals in its surveying process, because of stipulations related to insufficient patient volume necessary to meet minimum survey completion guidelines. Further, restricting which hospitals are included due to factors such as bed size and patient census may subject the HCAHPS data to selection bias. For example, Critical Access Hospitals (CAH) are exempt due to low bed size and the related

economic burden associated with coordinating the HCAHPS process with CMS; participation is voluntary for these hospitals with low patient count.

Even though a restricted version of HCAHPS data is publicly available, not all questions on the full HCAHPS survey are made public. Special procedures must be followed to gain access to patient demographic information and other HCAHPS items beyond the accessibility given to the average consumer. Furthermore, the data are only presented in aggregate at the hospital level to maintain anonymity of patients. This restriction of the data limits the scope of analysis when comparing Magnet to non-Magnet hospitals such as examining or controlling for potential differences in age, gender, education, and race. Further, hospital/survey vendors must have measures in place to protect patients' confidentiality (e.g., prevent unauthorized access to electronic or paper records, establish confidential agreements with Health Insurance Portability and Accountability Act, (HIPAA) like language to protect patient information. Additionally, hospitals with 25 or less completed surveys are restricted from publicly reporting HCAHPS scores (CMS, 2017).

Given that this study is quantitative in nature and is limited to the participants' subjective responses, there could be bias in how respondents perceived the interviewer from acoustic cues (e.g., accent). If there are acoustic differences in the way how the interviewee identified or perceived the phonetic sounds from the interviewer, then words could be interpreted differently. Thus, leading to response bias. Similarly, response bias can alter the results of patient satisfaction surveys potentially leading to a higher estimation of satisfaction level among patient population (Mazor et al., 2002).

Additionally, patient satisfaction is subjective and can be driven by a myriad of factors that patient's value such as nurse characteristics, room setting, and timing of nursing care (e.g., race, meal time); therefore, no sole survey can capture all potential drivers of patient satisfaction (Glickman et al., 2010). Further, the survey is voluntary and answering survey questions after discharge from a hospital requires the respondent to recall information and thus places cognitive demands on the individual; this retrospective recall may affect the answering process (Bowling, 2005).

### **Recommendations**

Based on the evidence of the findings, it is important that future research continue to investigate the relationship between Magnet-designation and patient outcomes such as patient satisfaction. Magnet-designation of hospitals was first awarded in 1994 (ANCC, 2018; Lippincott's Solution, 2016). Since then, this award of excellence has been achieved by nearly 9% of the hospital population (Brunsman, 2018; Gerardo, 2017). From my study results, it appears that patient satisfaction with specific nursing care can offer crucial and beneficial information to users (e.g., patients, nurse educators, policymakers) of healthcare regarding the overall quality of care without relying on hospital certifications (e.g., Magnet-designation). However, since the public rely on different media representations to inform them of trends in healthcare it is wise for non-Magnet hospitals to imitate the Magnet model. Accreditation agencies such as CMS highlights measures of quality and safety through hospital certifications and surveys thus, it is prudent economic sense for non-Magnet hospitals to use data provided from previous patients to attract potential ones. Therefore, healthcare policymakers should be cognizant



of evidence that shows patient satisfaction research results favorable to Magnet-designated hospitals and recommend that those features that lead to better results be adopted, implemented and practiced in non-Magnet hospitals.

Given study limitations such as patient demographics and limited number of surveys, it is important that future research accounts for the relationship between Magnet-designation, patient satisfaction, and patient outcomes (e.g., patient engagement, treatment adherence, patient autonomy in medical decisions, and patient psychological need for care). More research is needed on other healthcare services offered in Magnet-designated hospitals and patients' understanding of those services and the role their cultural values, socio-economic status, and emotional state plays in satisfaction and perception of those services. On the other hand, researchers need to investigate the role of nursing culture in the hospital and its influences on delivery of care. For example, lack of passion for change (seeking Magnet status) within the unit. On any given day a nursing unit is comprised of licensed and unlicensed personnel and other support staff. While everyone's goal is focused on caring for the patient there can be disconnection among the team for support of the change. Any lack of support for an expensive and grand change can lead to economic and organizational conflict.

Contrary to the expressed belief of the high expense of pursuing Magnet-designation, studies have revealed that Magnet-designated hospitals are more cost effective than non-Magnet hospitals. For example, Aiken, Silber, and McHugh (2016) explained that procedure costs at Magnet hospitals are less compared to non-Magnet hospitals. Further, the researchers indicated that care at Magnet-designated hospital is

significantly related to lower death rates after surgery and better nurse staffing which decreases hospital and patient care costs. Future research should continue to examine whether practices and standards at Magnet-designated hospitals result in improved cost-effectiveness, higher quality outcomes, and higher satisfaction in patient experiences when compared to non-Magnet designated hospitals or hospitals implementing Magnet processes without seeking formal designation.

### **Implications**

Nursing activities are salient factors that closely affect the patient care experience and therefore will strongly impact patient satisfaction. Common daily interactive experiences, such as cultural exchange, effective nursing communication, respect for others, treating patients with dignity, and educating limited English proficiency (LEP) patients in a language of choice are occurrences that are valued by patients (Berkowitz, 2016; Betancourt, Green, Carillo, & Park, 2015; Bowles & Mackintosh, & Torn, 2001; Karliner, Jacobs, Chen, & Mutha, 2007; Vertino, 2014; Wittenberg-Lyles et al., 2013). Implementing these nursing practices does not require the mass expense compared to applying for Magnet-designation. Inexpensive education and reinforcement of communicating basic common courtesy may play a substantial role in patient satisfaction. Previous research has demonstrated the potential to improve patient satisfaction through beneficial changes to nursing care. For example, in Radtke's 2013 experimental study to increase patient satisfaction scores with nurse communication, Radtke findings revealed that changes in how information was communicated to patients in the medical-surgical unit improved discharged patients' reported satisfaction with nursing communication.

Specifically, after three months of change to nurse communication, satisfaction ratings increased from 75% to 87.6% on their internal hospital survey.

Similarly, Witkoski-Stimpfel et al. (2016) used secondary data in a retrospective study to examine the relationship between Magnet-designation and patients' experience with their hospitalization according to HCAHPS scores. In this study, communication with nurses improved patient satisfaction. Nursing care played a pivotal role in how hospitals were viewed by patients. Witkoski-Stimpfel and others 2016 study on Magnet designation and patient experience results revealed patients' experience with hospital care is significantly related to whether hospitals have appropriate nurse governance (e.g., adequate nurse staffing, supportive work environments, and reasonable nurse work hours). Patient reports of positive experiences from nurses' communication support the results of my study. The results of Witkoski-Stimpfel and colleagues research revealed evidence that patients may benefit from increased nursing communication and interactive relationships; quality nursing care from the patient perspective may also further benefit from Magnet-designation.

In addition, results from my study may contribute new information to expand and improve policies, community-based services and programs to bring about change to promote the idea that everyone should have the right to healthcare provisions not the privilege to obtain and afford healthcare. Furthermore, all patients should have access to receive healthcare services and should have the right and the opportunity to express the perception of their experiences without fear of bias care. Some researchers expressed the belief that healthcare should be distributed on the basis of equity and equality (Daniels,

1997), while others disagree and argued that healthcare should be distributed using a voucher system to prevent inequalities. Regardless of the authors' views it is imperative that policy makers work closely with healthcare providers from the frontline such as nurses, to establish the health practices that change the ways healthcare is accessed. The fundamental access to healthcare services should be a basic right. Access to healthcare gives the individual the privilege to practice healthy physical, social and mental health. In addition, access encourages the individual to participate in the expression of patient experience without fear of bias or discrimination because of where care is delivered or from whom care is received.

### **Implication for Social Change**

The importance of patient satisfaction to healthcare leaders is in part linked to hospital reimbursements through the HCAHPS measurement. Therefore, my study's implications for social change are bolstered by the role of patient satisfaction, measured by HCAHPS, in today's healthcare climate. Measuring patient satisfaction with healthcare is beneficial to the overall health care industry and patient experience with care (Mehta, 2015). If patients are afforded the best clinical experience when they seek care, it can create potential positive impact within the health care industry. Further, studies have shown that patients' perceptions of quality care are often determined by the quality of their healthcare experiences such as interactions and communication with nurses and other staff (Clark, 2003; Wanzer, Booth-Butterfield, & Gruber, 2004). It is important that nurses are educated to practice cultural competence, effective nursing communication, respect for patients, treating patients with dignity, and use interpretation

and translation services to communicate with patients in a language of choice (Berkowitz, 2016; Betancourt, Green, Carillo, & Park, 2015; Bowles, Mackintosh, & Torn, 2001; Karliner, Jacobs, Chen, & Mutha, 2007; Vertino, 2014; Wittenberg-Lyles et al., 2013). Higher HCAHPS scores, through better positive patient satisfaction results, enable full reimbursement for healthcare services and often recognition from accrediting agencies as well as a favorable reputation with prospective patients.

### **Recommendations for Social Change**

Treating patients with dignity and respect are basic practices of nursing (ANA Position Paper, 2012, para. 1) yet are not consistently applied throughout the patients' healthcare experience. Through new government policy and hospital healthcare leaders, my social change recommendations center on the empowerment of nurses and patients.

Nurses often have the education, experience, and hospital resources to manage a wide spectrum of patient needs and interact with patients from a variety of social and demographic backgrounds; however, at times, nurses can be hampered by hospital barriers, administrative challenges, patient volume, and work climate among other issues (Nyholm & Koskinen, 2015; Wilson-Stronks & Galvez, 2009). For illustrative purposes, the care experience for patients with limited English proficiency may be diminished if nurses are unable to provide prompt interpretation or translation services due to routinely being faced with time constraints and inadequate staffing. For example, a patient with limited English proficiency may need medication administered by a nurse, but care will be delayed by waiting for translation services (Ngo-Metzger et al., 2007; Shi, Lebrun, & Tsai, 2009). Further, even with the translation service, the patient may become

dissatisfied with the ongoing, delayed care, and limited nurse-patient social interaction that typically demonstrates the nurse's compassion and sincere interest in the patient. In order to empower nurses to consistently deliver high quality and satisfactory patient care experiences, hospital organizations should implement policies and foster a positive nursing work culture (Bittner-Fagan, Davis, & Savoy, 2017; Wasserman et al., 2014), similar to that described of Magnet, which encourage adequate nurse staffing, nurse autonomy, and physician-nurse collaboration (McClure et al., 1983). Bolstering nurse empowerment can be achieved through hospitals adopting a culture of inclusiveness in decision making; for example, pairing senior leaders' top-down directives of new care strategy protocols with bottom-up input from nurses with practice-based experience and ideas grants nurses the acknowledgment and participation in the decisionmaking process (Linnen & Rowley, 2014; Wasserman et al., 2014; Wilson-Stronks & Galvez, 2009).

An important element of patient satisfaction is sense of control and independence; this desire extends beyond the clinical experience of the hospital stay. Patients prefer control and access of their electronic health records (EHR) data (Prey, Restiano, & Vawdrey, 2014). A meta-analysis of approximately 175 research studies, examining the impact of patients' EHR access on patient outcomes, revealed patients reported improved satisfaction (i.e., online electronic preference over standard provisions), improved self-reported self-care, and better engagement with clinical staff (Mold et al., 2015). Patients' medical information is fragmented and not properly disseminated. For example, hospitalized patients are not provided adequate information often enough about their plan of care (Agarwal, Anderson, Zarate, & Ward, 2013; Vydra, Cuaresma, Kretovics & Bose-

Brill, 2015). Patients should be given healthcare information freely and allowed to make informed decisions. Access to information empowers patients and will eventually make care more efficient, safer, less costly, and streamlined (Prey et al., 2014). To encourage meeting this demand, hospitals that not only initiate programs to make information more accessible to patients, but also demonstrate improvement of patient satisfaction specific to nursing care should be rewarded with higher percentage of reimbursements or additional incentive payments through CMS (Vydra et al., 2015). Further, physicians should be encouraged to support this initiative and work alongside the nurses to present a united front on patient advocacy (Vydra et al., 2015). Additionally, hospital healthcare leaders should work with unit managers to set a nursing culture that shares information with patient at more frequent intervals. Further, hospital administrators should establish a plan of action in place to regularly evaluate performance of this initiative and change aspects of the patient care experience process, including required use of certain tools, that do not support the timely delivery of care and information to patients. Building a framework of government and hospital factors to promote nurse and patient empowerment can encourage consistent high-quality nursing care interactions with patients yielding high satisfaction rates (Duffy, Yiu, Molokhia, Walker, & Perkins, 2010).

### **Conclusion**

Patient satisfaction has a significant relationship with Magnet designation. However, some healthcare organizations failed to identify nursing care activities as essential measures of patient experience which tremendously impacted patient

satisfaction. Patient satisfaction is subjective and can be affected or be influenced by a myriad of factors. Studies have identified patient characteristics (e.g., age, sex, race, socio-economic status, comorbidities, or health status) that may influence how a patient care experience is evaluated when answering questions on a satisfaction survey (Haviland et al., 2005; Parchman, Noel, & Lee, 2005; Thiedke, 2007).

Hospitalized patients have preconceived expectations and hope the nurse administering care is there to provide a satisfactory experience through positive nurse communication, cultural awareness and educational preparation (Lin, 2004; Oliver, 1980). Meanwhile, the nurses are hoping that the patients are satisfied with the care they delivered and will express satisfaction on their HCAHPS surveys. However, with all the different factors at play in the administration of healthcare it is difficult to predict patient satisfaction, but it is important to measure satisfaction to evaluate quality of care. Hence, more research is needed to reflect the characteristics of patients and their expectations prior to hospitalization.

Magnet-designated hospitals have championed their organizations as best places where patient satisfaction achieved, in the meantime, expanding their visibility across all states as leaders of patient healthcare expectations. Wood (2010) explained that a study by the University of Maryland compared nurse work schedules and working conditions in Magnet-designated and non-Magnet hospitals and found there were little difference in operations. Similarly, a cross sectional study by Kalisch and Lee (2012), revealed that there were no staffing-level differences between Magnet-designated and non-Magnet hospitals. However, Magnet-designated hospitals are placing emphasis on practices such



as better nurse staffing, quality nursing care, and excellent nursing services compared to non-Magnet hospitals. Factors they believe will ultimately improve HCAHPS scores from patient satisfaction surveys and increase hospital reimbursements (Smith, 2014; Wolosin, Ayala, & Fulton, 2012).

The purpose of this quantitative study project was to investigate if there were relationships between Magnet-designation and patient satisfaction with specific nursing care as specified by HCAHPS scores. The overall intent of this study was to reinforce the need for local hospital healthcare leaders and unit managers to identify diverse and simple ways to improve the hospital experience and achieve better patient satisfaction. Satisfaction is a complex phenomenon. The common measure for patient satisfaction for specific hospitals are established through the nationally assessed HCAHPS results, which provide an optimal comparison method to evaluate whether Magnet-designated hospitals are performing better and providing excellent nursing care compared to non-Magnet hospitals. The findings from this study suggest it is difficult to measure patient satisfaction given the multifaceted patient experience; patient satisfaction can be largely affected by their own characteristics, disposition of medical issue, nursing and medical staff characteristics, quality of hospital room setting, and the variety of patient-specific expectations and preferences. Therefore, further research is needed beyond HCAHPS to determine which factors (e.g., nurse education, nurse communication, and hospital culture) that encourage better patient satisfaction. With this growing knowledge of factors beneficial to patient satisfaction, hospitals can implement less costly Magnet-like status programs and protocols to champion better patient experience.

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## Appendix A: Hospital Consumer Assessment of Healthcare Providers and Systems

## Survey

## Survey Instructions

- ◆ You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient.
- ◆ Answer all the questions by checking the box to the left of your answer.
- ◆ You are sometimes told to skip over some questions in this survey. When this happens, you will see an arrow with a note that tells you what question to answer next, like this:

Yes

No → *If No, Go to Question 1*

*You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.*

*Please note: Questions 1-25 in this survey are part of a national initiative to measure the quality of care in hospitals. OMB #0938-0981*

Please answer the questions in this survey about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

## YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?

1  Never

2  Sometimes

3  Usually

4  Always

2. During this hospital stay, how often did nurses listen carefully to you?

1  Never

2  Sometimes

3  Usually

4  Always



3. During this hospital stay, how often did nurses explain things in a way you could understand?

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always
- 5  I never pressed the call button

#### **YOUR CARE FROM DOCTORS**

**5. During this hospital stay, how often did doctors treat you with courtesy and respect?**

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always

**6. During this hospital stay, how often did doctors listen carefully to you?**

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always

**7. During this hospital stay, how often did doctors explain things in a way you could understand?**

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always

**THE HOSPITAL ENVIRONMENT**

**8. During this hospital stay, how often were your room and bathroom kept clean?**

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always

**9. During this hospital stay, how often was the area around your room quiet at night?**

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always

**YOUR EXPERIENCES IN THIS HOSPITAL**

**10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?**

- 1  Yes
- 2  No → If No, Go to Question 12

**11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?**

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always

**12. During this hospital stay, did you need medicine for pain?**

- 1  Yes
- 2  No → If No, Go to Question 15

**13. During this hospital stay, how often was your pain well controlled?**

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always

**14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?**

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always

**15. During this hospital stay, were you given any medicine that you had not taken before?**

- 1  Yes
- 2  No → If No, Go to Question 18

**16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?**

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always

**17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?**

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always

#### **WHEN YOU LEFT THE HOSPITAL**

**18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?**

- 1  Own home
- 2  Someone else's home
- 3  Another health facility → If Another, Go to Question 21

**19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?**

- 1  Yes
- 2  No

**20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?**

- 1  Yes  
2  No

#### **OVERALL RATING OF HOSPITAL**

**Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.**

**21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?**

- 0  0 Worst hospital possible  
1  1  
2  2  
3  3  
4  4  
5  5  
6  6  
7  7  
8  8  
9  9  
10  10 Best hospital possible

**22. Would you recommend this hospital to your friends and family?**

- 1  Definitely no  
2  Probably no  
3  Probably yes  
4  Definitely yes

#### **UNDERSTANDING YOUR CARE WHEN YOU LEFT THE HOSPITAL**

**23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.**

- 1  Strongly disagree  
2  Disagree  
3  Agree  
4  Strongly agree

**24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.**

- 1  Strongly disagree
- 2  Disagree
- 3  Agree
- 4  Strongly agree

**25. When I left the hospital, I clearly understood the purpose for taking each of my medications.**

- 1  Strongly disagree
- 2  Disagree
- 3  Agree
- 4  Strongly agree
- 5  I was not given any medication when I left the hospital

**ABOUT YOU**

**There are only a few remaining items left.**

**26. During this hospital stay, were you admitted to this hospital through the Emergency Room?**

- 1  Yes
- 2  No

**27. In general, how would you rate your overall health?**

- 1  Excellent
- 2  Very good
- 3  Good
- 4  Fair
- 5  Poor

**28. In general, how would you rate your overall mental or emotional health?**

- 1  Excellent
- 2  Very good
- 3  Good
- 4  Fair
- 5  Poor

**29. What is the highest grade or level of school that you have completed?**

- 1  8th grade or less
- 2  Some high school, but did not graduate
- 3  High school graduate or GED
- 4  Some college or 2-year degree
- 5  4-year college graduate
- 6  More than 4-year college degree

**30. Are you of Spanish, Hispanic or Latino origin or descent?**

- 1  No, not Spanish/Hispanic/Latino
- 2  Yes, Puerto Rican
- 3  Yes, Mexican, Mexican American, Chicano
- 4  Yes, Cuban
- 5  Yes, other Spanish/Hispanic/Latino

**31. What is your race? Please choose one or more.**

- 1  White
- 2  Black or African American
- 3  Asian
- 4  Native Hawaiian or other Pacific Islander
- 5  American Indian or Alaska Native

**32. What language do you mainly speak at home?**

- 1  English
- 2  Spanish
- 3  Chinese
- 4  Russian
- 5  Vietnamese
- 6  Portuguese
- 7  Some other language (please print): \_\_\_\_\_

**THANK YOU**

**Please return the completed survey in the postage-paid envelope.**

**[NAME OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]**

**[RETURN ADDRESS OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]**

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## Appendix B: List of Magnet Hospitals

<b>Hospital Name</b>	<b>Bed Size</b>	<b>City</b>	<b>State</b>	<b>Year</b>
Alaska Native Medical Center	152	Anchorage	AK	2003
UAB Hospitals	1155	Birmingham	AL	2002
CHI St. Vincent Infirmiry	432	Little Rock	AR	2013
Banner-University Medical Center Phoenix	733	Phoenix	AZ	2005
Banner -University Medical Center	685	Phoenix	AZ	2015
Honor Health Deer Valley Medical Center	204	Phoenix	AZ	2015
HonorHealth Scottsdale Shea Medical Center	421	Scottsdale	AZ	2011
HonorHealth Scottsdale Thompson Peak Medical Center	92	Scottsdale	AZ	2011
Honor Health Scottsdale Osborn Medical Center	340	Scottsdale	AZ	2006
Honor Health John C. Lincoln Medical Center	262	Scottsdale	AZ	2006
Banner-University Medical Center Tucson	479	Tucson	AZ	2003
John Muir Medical Center, Concord	245	Concord	CA	2010
North bay Health Group	182	Fairfield	CA	2014
Washington Hospital	318	Fremont	CA	2011
St. Jude Memorial Center	344	Fullerton	CA	2015
Scripps Memorial Hospital La Jolla	347	La Jolla	CA	2015
Sharp Grossmont Hospital	528	La Mesa	CA	2006
Long Beach Memorial Medical Center	458	Long Beach	CA	2013
Cedars-Sinai	880	Los Angeles	CA	2000
Providence Holy Cross Medical Center	377	Mission Hills	CA	2007
Mission Hospital	523	Mission Viejo	CA	2012
El Camino Hospital Mountain View	443	Mountain View	CA	2008
Hoag Memorial Hospital Presbyterian	527	Newport Beach	CA	2005
St. Joseph's Hospital	463	Orange	CA	2007
UC Irvine Health	411	Orange	CA	2003
Stanford Health care	481	Palo Alto	CA	2007
Huntington Hospital	580	Pasadena	CA	2015
Eisenhower Medical Center	381	Rancho Mirage	CA	2008
UC Davis Medical Center	583	Sacramento	CA	2014
Sharp Mary Birch Hospital for Women and Newborns		San Diego	CA	2008



<b>Hospital Name</b>	<b>Bed Size</b>	<b>City</b>	<b>State</b>	<b>Year</b>
UC San Diego Health	542	San Diego	CA	2011
University of California, San Francisco Medical Center	650	San Francisco	CA	2012
Torrance Memorial Medical Center	649	Torrance	CA	2011
John Muir Medical Center, Walnut Creek	554	Walnut Creek	CA	2008
The Medical Center of Aurora/Centennial Medical Plaza	323	Aurora	CO	2008
University of Colorado Hospital	570	Aurora	CO	2002
Penrose-St Francis Health Services	421	Colorado Springs	CO	2014
Porter Adventist Hospital	236	Denver	CO	2009
Craig Hospital	93	Englewood	CO	2005
Poudre Valley Hospital	219	Fort Collins	CO	2000
Medical Center of the Rockies	166	Loveland	CO	2010
St. Vincent Medical Center	403	Bridgeport	CT	2012
Bristol Hospital	128	Bristol	CT	2015
Middlesex Hospital	229	Middletown	CT	2001
Yale New Haven Hospital	1541	New Haven	CT	2011
MedStar George Town University Hospital	744	Washington	DC	2004
Bay Health	281	Dover	DE	2015
Christiana Care Health System	1021	Wilmington	DE	2010
Baptist Health System- Baptist Medical Center Nassau	54	Fernandina Beach	FL	2007
Holy Cross Health Ministries	358	Fort Lauderdale	FL	2003
UF Health Shands	588	Gainesville	FL	2003
Mayo Clinic	249	Jacksonville	FL	2015
UF Health Jacksonville	582	Jacksonville	FL	2011
Baptist Medical center South	269	Jacksonville	FL	2007
Baptist Medical Center Downtown	915	Jacksonville	FL	2007
Baptist Medical Center Beaches	136	Jacksonville Beach	FL	2007
Mercy Hospital, A Campus of Plantation General Hospital	343	Miami	FL	2003
West Kendall Baptist Hospital	133	Miami	FL	2015
Baptist Hospital of Miami	728	Miami	FL	1998
Sarasota Memorial Health Care System	632	Sarasota	FL	2003
South Miami Hospital	364	South Miami	FL	2004
Flagler Hospital Inc	335	St. Augustine	FL	2006

<b>Hospital Name</b>	<b>Bed Size</b>	<b>City</b>	<b>State</b>	<b>Year</b>
Tampa General	964	Tampa	FL	2005
Winter Haven	529	Winter Haven	FL	2008
Emory St. Joseph Hospital	262	Atlanta	GA	1995
Emory University	528	Atlanta	GA	2014
University Hospital	495	Augusta	GA	2005
Atlanta VA Medical Center	239	Decatur	GA	2009
The Medical Center Navicent Health	580	Macon	GA	2005
St. Joseph's/Candler Hospital	256	Savannah	GA	2002
The Queens's Medical Center	505	Honolulu	HI	2009
Unity Point Health St. Luke's Hospital	346	Cedar Rapids	IA	2009
Mercy Medical Center - Clinton	290	Clinton	IA	2015
CHI Mercy Health Council Bluffs	148	Councils Bluffs	IA	2005
Genesis Medical Center	302	Davenport	IA	2005
Mercy Medical Center - Dubuque and Dyersville Campuses	235	Dubuque	IA	2004
University of Iowa Hospitals and Clinics	714	Iowa City	IA	2004
Waverly Health Center	25	Waverly	IA	2014
St. Lukes Regional Medical Center (Treasure Valley)	574	Boise	ID	2001
Kootenai Health	292	Coeur d Alene	ID	2006
Northwest Community Health Care	368	Arlington Heights	IL	2006
Advocate Good Shepard Hospital	176	Barrington	IL	2013
Memorial Regional Health Services	216	Belleville	IL	2008
McNeal Hospital	297	Berwyn	IL	2012
Advocate Illinois Masonic Medical Center	397	Chicago	IL	2008
Northwestern Memorial Hospital	875	Chicago	IL	2006
Rehabilitation Institute of Chicago	182	Chicago	IL	2005
Rush University Medical Center	679	Chicago	IL	2002
Swedish Covenant Hospital	316	Chicago	IL	2010
Advocate Good Samaritan Hospital	340	Downers Grove	IL	2009
Advocate Sherman Hospital	255	Elgin	IL	2012
Elmhurst Memorial Healthcare	282	Elmhurst	IL	2015
Northshore University Health System Evanston Hosp	354	Evanston	IL	2010
NorthShore University Health System- Skokie	123	Evanston	IL	2010

<b>Hospital Name</b>	<b>Bed Size</b>	<b>City</b>	<b>State</b>	<b>Year</b>
Northwestern Medicine Delnor Hospital	159	Geneva	IL	2004
NorthShore University Health System – Glenbrook	173	Glenview	IL	2010
Mercy Health System - Mercy Harvard Hospital	288	Harvard	IL	2014
NorthShore University Health System - Highland Park Hospital	139	Highland Park	IL	2010
AMITA Health Adventist Hinsdale Hospital	291	Hinsdale	IL	2015
Riverside Medical Center	335	Kankakee	IL	2011
Northwestern Lake Forest Hospital	117	Lake Forest	IL	2010
Loyola University medical center	505	Maywood	IL	2009
Centegra Health System- McHenry	173	McHenry	IL	2013
Edward Hospital	298	Naperville	IL	2005
Advocate Christ Medical Center	749	Oak Lawn	IL	2005
Advocate Lutheran General Hospital	638	Park Ridge	IL	2005
Unity Point Health Methodist	295	Peoria	IL	2004
OSF - Saint Francis Medical Center	648	Peorie	IL	2004
OSF - Saint Anthony Medical Center	235	Rockford	IL	2005
Swedish American Health System	306	Rockford	IL	2015
Memorial Medical Center	469	Springfield	IL	2006
Carle Foundation Hospital and Carle Physician Group	376	Urbana	IL	2009
Northwestern Medicine Central Dupage Hospital	379	Winfield	IL	2010
Centegra Health System- Woodstock	131	Woodstock	IL	2013
Passavant Area Hospital	108	Jacksonville	IL	2009
Indiana University Health West Hospital	127	Avon	IN	2014
Indiana University Health Bloomington Hospital	273	Bloomington	IN	2010
Indiana University Health North Hospital	149	Caramel	IN	2015
Hendricks Regional Health	127	Danville	IN	2010
Deaconess Hospital Inc	506	Evansville	IN	2013
St. Mary's Medical Center	443	Evansville	IN	2011
Goshen Hospital (formerly IU Health Goshen Hospital)	123	Goshen	IN	2004
Indiana University Health Methodist Hospital	1241	Indianapolis	IN	2004

<b>Hospital Name</b>	<b>Bed Size</b>	<b>City</b>	<b>State</b>	<b>Year</b>
Indiana University Health University Hospital (reports as consolidated with Methodist)	-	Indianapolis	IN	2014
Marion General	115	Marion	IN	2008
Schneck Medical Center	93	Seymour	IN	2011
Good Samaritan Hospital	239	Vincennes	IN	2008
The University of Kansas Hospital	740	Kansas	KS	2006
Stormont Vail Health	400	Topeka	KS	2009
St. Elizabeth Healthcare - Edgewood Covington and Grant	492	Edgewood	KY	2006
Frankfort Regional Medical Center	109	Frankfort	KY	2011
Baptist Health Lexington	360	Lexington	KY	2005
Baptist Health Louisville	519	Louisville	KY	2008
Our Lady of the Lake Regional Medical Center	473	Baton Rouge	LA	2014
Woman's Hospital	216	Baton Rouge	LA	2006
East Jefferson General	424	Metairie	LA	2002
Ochsner Medical Center Acute Care	473	New Orleans	LA	2003
Dana Faber Cancer Institute	10	Boston	MA	2005
Massachusetts General Hospital	999	Boston	MA	2003
Lowell General Hospital	396	Lowell	MA	2010
Hallmark Health Lawrence Memorial Hospital Campus	250	Medford	MA	2014
Hallmark Health Melrose Wakefield Hospital Campus; consolidated	-	Melrose	MA	2014
South Shore Hospital	368	South Weymouth	MA	2009
Baystate Medical Center	710	Springfield	MA	2005
Winchester	205	Winchester	MA	2003
MedStar Franklin Square Medical Center	376	Baltimore	MD	2008
Anne Arundel Medical Center	384	Annapolis	MD	2014
Mercy Medical Center	262	Baltimore	MD	2011
Sinai Hospital of Baltimore	428	Baltimore	MD	2008
The John Hopkins Hospital	993	Baltimore	MD	2003
University of Maryland Medical Center	715	Baltimore	MD	2009
University of Maryland Shore Regional Health	171	Easton	MD	2009
Mid Coast Hospital	92	Brunswick	ME	2009

<b>Hospital Name</b>	<b>Bed Size</b>	<b>City</b>	<b>State</b>	<b>Year</b>
Maine Medical Center	637	Portland	ME	2006
DMC Huron Valley-Sinai Hospital	111	Commerce Township	MI	2009
VHS/DMC - Rehabilitation Institute of Michigan	69	Detroit	MI	2013
Mercy Health Saint Mary's	371	Grand Rapid's	MI	2013
Bronson Methodist Hospital	410	Kalamazoo	MI	2009
Sparrow Hospital	624	Lansing	MI	2009
McLaren Northern Michigan	202	Petoskey	MI	2015
Beaumont Hospital, Royal Oak	1070	Royal Oak	MI	2004
Munson Medical Center	391	Traverse City	MI	2006
Beaumont Hospital, Troy	458	Troy	MI	2009
Abbott Northwestern Hospital	662	Minneapolis	MN	2009
Mayo Clinic in Rochester	1243	Rochester	MN	1997
St. Cloud Hospital	495	St. Cloud	MN	2004
Boone Hospital Center	321	Columbia	MO	2005
Saint Luke's Hospital of Kansas City	404	Kansas City	MO	2004
St. Joseph Medical Center	187	Kansas City	MO	2004
Barnes-Jewish Hospital	1394	St. Louis	MO	2003
Billings Clinic	279	Billings	MT	2006
Providence St. Patrick Hospital	208	Missoula	MT	2013
University of North Carolina Hospitals	778	Chapel	NC	2010
Carolinas Medical Center	100	Charlotte	NC	2013
Duke University Health System	919	Durham	NC	2014
Caromont Regional Medical Center	370	Gastonia	NC	2007
Cone Health - Moses Cone Hospital	1018	Greensboro	NC	2005
Cone Health - Wesley Long Community Hospital	175	Greensboro	NC	2005
Cone Health - Women's Hospital	Specialty	Greensboro	NC	2005
Vidant Medical Center	909	Greenville	NC	2013
Catawba Valley Medical Center	258	Hickory	NC	2001
Southeastern Health	452	Lumberton	NC	2008
UNC Rex Healthcare	665	Raleigh	NC	2006
WakeMed Health and Hospitals	567	Raleigh	NC	2015
Novant Health Forsyth Medical Center	706	Winston Salem	NC	2004
Sanford Bismarck	218	Bismarck	ND	2008

<b>Hospital Name</b>	<b>Bed Size</b>	<b>City</b>	<b>State</b>	<b>Year</b>
CHI Health Good Samaritan	265	Kearney	NE	2015
CHI Health St. Elizabeth	260	Lincoln	NE	2004
CHI Health Lakeside	84	Omaha	NE	2008
Nebraska Medicine - Nebraska Medical Center	518	Omaha	NE	2007
Nebraska Methodist Hospital	366	Omaha	NE	2004
Exeter Hospital, Inc	97	Exeter	NH	2013
Southern New Hampshire Medical Center	169	Nashua	NH	2006
St. Joseph Hospital	208	Nashua	NH	2005
AtlantiCare Regional Medical Center (2 campuses)	540	Atlantic City	NJ	2004
Meridian Health- Ocean Medical Center (was Medical Center of Ocean County)	265	Brick	NJ	1998
Inspira Medical Centers-Elmer Hospital	83	Elmer	NJ	2008
Englewood Hospital & Medical Center	326	Englewood	NJ	2002
Hunterdon Healthcare System	184	Flemington	NJ	2008
CentraState Medical Center	264	Freehold	NJ	2005
Hackensack University Medical Center	688	Hackensack	NJ	1995
Jersey City Medical Center- RWJ Barnabas Health	298	Jersey City	NJ	2008
Morristown Medical Center	719	Morristown	NJ	2001
Meridian Health- Jersey Shore Medical Center	548	Neptune	NJ	1997
Robert Wood Johnson University Hospital	610	New Brunswick	NJ	1997
Saint Peter's University Hospital	348	New Brunswick	NJ	1998
St. Joseph's Regional Medical Center	734	Paterson	NJ	1999
Raritan Bay Medical Center	276	Perth Amboy	NJ	2004
University Medical Center of Princeton at Plainsboro	341	Plainsboro	NJ	2012
Meridian Health-Riverview Medical Center	276	Red Bank	NJ	1998
The Valley Hospital	426	Ridgewood	NJ	2003
Robert Wood Johnson University Hospital Somerset	274	Somerville	NJ	2011
Holy Name Medical Center	307	Teaneck	NJ	2009
Capital Health System-Fuld Campus	202	Trenton	NJ	2002
Capital Health System-Mercer Campus	closed	Trenton	NJ	2002

<b>Hospital Name</b>	<b>Bed Size</b>	<b>City</b>	<b>State</b>	<b>Year</b>
Inspira Medical Centers-Regional Medical Center (does not include Inspira)	325	Vineland	NJ	2008
St. Peter's Hospital	482	Albany	NY	2005
Our lady of Lourdes memorial Hospital, Inc.	148	Binghamton	NY	2007
F.F. Thompson Hospital	291	Canandaigua	NY	2004
New York Presbyterian Hudson Valley Hospital	128	Cortlandt Manor	NY	2007
Huntington Hospital	298	Huntington	NY	2004
Northern Westchester Hospital	195	Mount Kisco	NY	2012
Long Island Jewish Medical Center	940	New Hyde park	NY	2015
Hospital for Special Surgery	201	New York	NY	2002
New York Eye and Ear Infirmary of Mount Sinai	27	New York	NY	2009
NYU Hospital for Joint Diseases	160	New York	NY	2012
NYU Hospitals Center (Tisch/Rusk)	725	New York	NY	2005
The Mount Sinai Medical Center, Manhattan	1138	New York	NY	2004
South Nassau Communities Hospital	407	Oceanside	NY	2014
John T. Mather Memorial Hospital	248	Port Jefferson	NY	2013
Rochester General Hospital	516	Rochester	NY	2004
University of Rochester Medical Center/Strong Memorial Hospital	830	Rochester	NY	2004
Highland Hospital	240	Rochester	NY	2011
St. Francis Hospital - The Heart Center	364	Roslyn	NY	2015
Saratoga Hospital	207	Saratoga Springs	NY	2004
St. Joseph's Health Hospital Health Center	451	Syracuse	NY	2013
White Plains Hospital	292	White Plains	NY	2012
Akron General Medical Center	414	Akron	OH	2013
Mercy Health - St. Elizabeth Boardman Hospital	206	Boardman	OH	2011
Aultman Hospital	534	Canton	OH	2006
The Christ Hospital	529	Cincinnati	OH	2015
TriHealth Bethesda North Hospital	367	Cincinnati	OH	2012
TriHealth Good Samaritan Hospital	504	Cincinnati	OH	2012
Cleveland Clinic	1285	Cleveland	OH	2003

<b>Hospital Name</b>	<b>Bed Size</b>	<b>City</b>	<b>State</b>	<b>Year</b>
Fairview Hospital	426	Cleveland	OH	2009
MetroHealth System	607	Cleveland	OH	2005
University Hospitals Cleveland Medical Center	670	Cleveland	OH	2006
Grant Medical Center	434	Columbus	OH	2005
OhioHealth Riverside Methodist Hospital	710	Columbus	OH	2006
Good Samaritan Hospital	499	Dayton	OH	2009
Miami Valley Hospital	845	Dayton	OH	2004
Mercy Health - Fairfield Hospital	214	Fairfield	OH	2014
Hilcrest Hospital	378	Mayfield Heights	OH	2014
Southern Ohio Medical Center	210	Portsmouth	OH	2008
University Hospitals Portage Medical Center	104	Ravenna	OH	2006
St. Joseph Warren Hospital	131	Warren	OH	2002
Mercy Health Youngstown	550	Youngstown	OH	2002
St. Elizabeth Youngstown Hospital	401	Youngstown	OH	2002
INTEGRIS Baptist Medical Center	564	Oklahoma	OK	2007
St. John Medical Center	543	Tulsa	OK	2010
Oregon Health & Science University	573	Portland	OR	2012
Providence Portland Medical Center	390	Portland	OR	2005
Providence St. Vincent Medical Center	464	Portland	OR	2000
VA Portland Healthcare System	72 Rehab	Portland	OR	2006
Salem Hospital	421	Salem	OR	2010
Abington Memorial Hospital	608	Abington	PA	2003
Lehigh Valley Health Network Home Health Services	942	Allen Town	PA	2002
Main Line Health - Bryn Mawr Hospital	319	Bryn Mawr	PA	2005
Holy Spirit Hospital	307	Camp Hill	PA	2013
Geisinger Medical Center	557	Danville	PA	2008
Pinnacle health System - Community General Hospital	114	Harrisburg	PA	2006
Penn State Health Milton S. Hershey Medical Center	541	Hershey	PA	2007
Lancaster General Hospital	601	Lancaster	PA	2002
Main Line Health - Bryn Mawr Rehabilitation Hospital	Specialty	Malvern	PA	2015



<b>Hospital Name</b>	<b>Bed Size</b>	<b>City</b>	<b>State</b>	<b>Year</b>
Main Line Health - Riddle Hospital	227	Media	PA	2015
Main Line Health - Paoli Hospital	226	Paoli	PA	2005
Hahnemann University Hospital	399	Philadelphia	PA	2007
Hospital of the University of Pennsylvania	759	Philadelphia	PA	2007
Penn Presbyterian Medical Center	343	Philadelphia	PA	2012
Pennsylvania Hospital	391	Philadelphia	PA	2015
Fox Chase Cancer Center	Specialty	Pittsburg	PA	2012
UPMC Shadyside	443	Pittsburg	PA	2010
UPMC St. Margaret	246	Pittsburg	PA	2009
West Penn Hospital	317	Pittsburg	PA	2006
The Chester County Hospital	248	West Chester	PA	2014
Main Line Health - Lankenau medical Center	389	Wynnewood	PA	2005
Newport Hospital	129	Newport	RI	2004
The Miriam Hospital	247	Providence	RI	1998
Bon Secours St. Francis Hospital	204	Charleston	SC	2010
MUSC Health	709	Charleston	SC	2015
Rapid City Regional Hospital	369	Rapid City	SD	2015
Avera McKennan Hospital & University Health Center	415	Sioux Falls	SD	2001
Sanford USD Medical Center	545	Sioux Falls	SD	2003
The University of Tennessee Medical Center	536	Knoxville	TN	2011
Texas Health Arlington Memorial Hospital	312	Arlington	TX	2014
Seton Medical Center Austin	106	Austin	TX	2002
University Medical Center Brackenridge	399	Austin	TX	2002
CHRISTUS Hospital	425	Beaumont	TX	2007
Baylor Jack and Jane Hamilton Heart Vascular Hospital	54	Dallas	TX	2007
Baylor University Medical Center	187	Dallas	TX	2004
Texas Health Presbyterian Hospital Dallas	634	Dallas	TX	2006
Medical City Denton	184	Denton	TX	2012
Medical City Fort Worth	220	Fort Worth	TX	2010
Texas Health Harris Methodist Hospital Fort Worth	645	Fort Worth	TX	2004
University of Texas Medical Branch	566	Galveston	TX	2012

<b>Hospital Name</b>	<b>Bed Size</b>	<b>City</b>	<b>State</b>	<b>Year</b>
Baylor Regional Medical Center at Grapevine	302	Grapevine	TX	2012
CHI St. Luke's Health Baylor St. Luke's Medical Center	678	Houston	TX	2001
Houston Methodist Hospital	191	Houston	TX	2002
Houston Methodist Willowbrook Hospital	313	Houston	TX	2013
Memorial Hermann Memorial City Medical City	375	Houston	TX	2009
Memorial Hermann Texas Medical Center	960	Houston	TX	2014
Michael E. DeBakey VA Medical Center	538	Houston	TX	2004
University of Texas MD Anderson Cancer Center	Specialty	Houston	TX	2001
Baylor Scott & Wine Medical Center Irving	207	Irving	TX	2013
Medical Center of Lewisville	179	Lewisville	TX	2015
Baylor Regional Medical Center at Plano	122	Plano	TX	2012
Medical City Plano	383	Plano	TX	2007
Texas Health Presbyterian Hospital Plano	386	Plano	TX	2007
University Health System	622	San Antonio	TX	2010
Memorial Hermann The Woodlands Hospital	351	The Woodlands	TX	2010
Virginia Hospital Center	350	Arlington	VA	2014
Lewis Gale Hospital Montgomery	88	Blacksburg	VA	2009
Sentara Martha Jefferson Hospital	150	Charlottesville	VA	2006
University of Virginia Health System	581	Charlottesville	VA	2015
Inova Fair Oaks Hospital	182	Fairfax	VA	2009
Mary Washington Hospital	421	Fredericksburg	VA	2009
Sentara RMH Medical Center	238	Harrisonburg	VA	2014
Inova Loudoun Hospital	279	Leesburg	VA	2006
Centra Health, Inc	661	Lynchburg	VA	2005
Bon Secours Memorial Regional Medical Center	224	Mechanicsville	VA	2009
Bon Secours St. Francis Medical Center	130	Midlothian	VA	2015
Sentara Leigh Hospital	250	Norfolk	VA	2015
Sentara Norfolk General Hospital	525	Norfolk	VA	2008
Bon Secours St. Mary's Hospital	410	Richmond	VA	2008
VCU Medical Center	761	Richmond	VA	2006

<b>Hospital Name</b>	<b>Bed Size</b>	<b>City</b>	<b>State</b>	<b>Year</b>
Carilion Clinics Roanoke Campus	691	Roanoke	VA	2003
Sentara Williamsburg Regional Medical Center	145	Williamsburg	VA	2014
Winchester Medical Center	455	Winchester	VA	2008
Southwestern Vermont Medical Center	78	Bennington	VT	2002
Rutland Regional Medical Center	123	Rutland	VT	2010
Providence St. Peter Hospital	339	Olympia	WA	2010
University of Washington Medical Center	429	Seattle	WA	1994
Mercy Health System	233	Janesville	WI	2014
Mercy Health System - Mercy Walworth Hospital	25	Lake Geneva	WI	2014
SSM Health St. Mary's Hospital - Madison	370	Madison	WI	2002
UW Health (Not Medical Foundation Clinics)	603	Madison	WI	2009
VA William S. Middleton Memorial Veterans Hospital	134	Madison	WI	2010
Aurora St. Luke's Medical Center	937	Milwaukee	WI	2001
Froedtert Hospital	536	Milwaukee	WI	2006
Wheaton Franciscan - St. Joseph Campus	350	Milwaukee	WI	2008
Aspirus Wausau Hospital	239	Wausau	WI	2005
West Virginia University Healthcare	461	Morgantown	WV	2005

The source of the information in this Appendix is  
<https://www.nursingworld.org/organizational-programs/magnet/find-a-magnet-facility>