Advances in Nursing and Midwifery
Original Article
Summer 2022, Volume 31, Issue 2 (16-27)

Patient's Perception of Safety in the Hospital Settings: A Qualitative Systematic Review

Sahar Dabaghi [1], **Mitra Zandi** [2,*], **Abbas Abbaszadeh** [3], **Abbas Ebadi** [4,5]

[1] Assistant Professor, Department of Community Health Nursing, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran

[2] Post Doc in Nursing, Associated Professor, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran

[3] Professor, Nursing and Midwifery School, Shahid Beheshti University of Medical Sciences, Tehran, Iran

[4] Professor, Behavioral Sciences Research Center, Life Style Institute, Baqiyatallah University of Medical Sciences, Tehran, Iran

[5] Faculty of Nursing, Baqiyatallah University of Medical Sciences, Tehran, Iran

**Corresponding author: Mitra Zandi, Post Doc in Nursing, Associated Professor, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran. E-mail: mitra.zandi@sbmu.ac.ir*

DOI: 10.22037.jnm.v31i2.39765

Submitted: 04 Dec 2021
Accepted: 14 Feb 2022
Published: 15 Apr 2022

Keywords:
Systematic Review
Qualitative Research
Safety
Patients
Patient Safety Hospitalization
Perception

© 2022. Advances in Nursing and Midwifery

How to cite:
Dabaghi S, Zandi M, Abbaszadeh A, Ebadi A. Patient's Perception of Safety in the Hospital Settings: A Qualitative Systematic Review. *Adv Nurs Midwifery*. 2022;31(**2**):16-27. doi: 10.22037.jnm.v31i2.39765

Abstract

Introduction: Patient safety is a key indicator and element in securing quality healthcare and this goal is multi-step, systemic, and multidisciplinary. The aim of the study was to investigate the meanings and definitions of "feeling of safety" in patient's view and experiences during their hospital stay and to identify the antecedents and consequences of the concept.

Methods: This qualitative systematic review was carried out based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2009. Six databases (PubMed, Web of Science, Scopus, ProQuest, Embase, Cochrane) were searched up to 2019 with no time and language limit. Two authors individually evaluated the study quality using Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI). Data from studies meeting the inclusion criteria were analyzed with concept analysis using of Walker and Avant approach (2011).

Results: Twenty-five papers were included in this study. Data analysis resulted finally in eleven main categories: "receiving safe care", "appropriate physical environment", "resorting to spirituality", "having previous negative experiences", and "presence of family and friends", "Feeling of Protection in a Safe Place", "Emotional Enrichment and Confidence", "Comfort and Tranquility", "Feeling of Control on the Situation", "Optimism towards Life" and "Coping".

Conclusions: Safe care is one of the fundamental needs in creating feeling of safety in patients. Focusing on this type of patient-centered care may promote quality care and improve the treatments provided in the hospital setting.

INTRODUCTION

Patient safety is a key indicator and element in securing quality healthcare and this goal is multi-step, systemic, and multidisciplinary [1, 2]. The goal of patient safety is to create safe care for the patient and personnel [3]. Most studies on patient safety have been carried out in hospital settings since most of the safety events have been identified in hospitals. As a result, the need for patient safety research is prioritized in hospitals and care-giving settings. Unfortunately, despite the studies of patient safety, adverse events and their negative consequences occur frequently in medical settings due to the complexity of the health care environment and the

Copyright © 2022 The Author(s); Published by Advances in Nursing and Midwifery. This is an open access article, distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses /by-nc/4.0/) which permits others to copy and redistribute material just in noncommercial usages, provided the original work is properly cited.

impact of multiple factors on the provision of safe care, so WHO offers guidelines and many steps for safe care to the healthcare team [4].

Evidence indicates that patients are sensitive supervisors in their self-care and their perceptions and experiences play an important role in their awareness of the overt and covert problems in the healthcare settings [5]. Researchers found "being safe" is not the same as "feeling safe" [6, 7]. Therefore, many studies have been done to understand the patient's experience and perspective of the concept of safety. Russell (1999) as a researcher who first explored the concept of patient safety in intensive care units expressed Feeling safe is an emotional state [8]. After Russell, other researchers explored this concept in intensive care units such as the ICU and CCU [6, 9, 10]. Initially, it was assumed that "safety" gains its meaning in the ICU where the patient spends much time during hospital stay. In the course of time, more studies were conducted in various wards like surgery and obstetric wards [11-15]. In each of these studies, the researchers tried to provide a definition of the concept using different qualitative methods such as phenomenology, content analysis, and grounded theory. With increasing number of qualitative studies, some scholars explored different aspects of the concept in systematic reviews. For example, Mollon (2013) investigated "patient safety" using a systematic review wherein an attempt was made to determine the antecedents, attributes, and consequences of safety and provide a definition of the term [7]. Following this, other researchers carried out some review studies in ICUs and even in primary care units [16, 17]. Despite the numerous studies accomplished to clarify the meaning of "patient safety", there are many disparities in the definitions of the term at the interdisciplinary and intradisciplinary levels [18]. For instance, many studies have used the terms "safety" and "security" interchangeably; so, there is no distinct border between the meanings of these two terms [6, 7]. Moreover, the studies conducted in the course of time in various hospital wards and healthcare settings have led to inaccessibility of a comprehensive definition of the term to be used by all members of a given discipline. This lack of certainty on the concept originates from the poor recognition of the attributes of the concept of safety from the patient perspective. The aim of the study was a systematic review of the qualitative studies related to meanings and definitions of "feeling of safety" in patient's view and experiences during their hospital stay and to identify the antecedents and consequences of the concept.

METHODS

Study Design

The present study was carried out based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2009 [19].

Search Strategy

Eligible studies were identified by searching the following online databases: PubMed, Web of Science, Scopus, ProQuest, Embase, Cochrane Library with no time and language limit until 2019-12-5. A number of key terms including "Patient's perception" OR "Patient's experiences" OR "Patient's view" OR "Patient's perspective" OR "Patient's expectations" OR "understanding" AND "safety" OR "Security" OR "Sense of security" OR "Sense of safety" OR "Feeling safe" OR "Feeling secure" OR "Feeling of safety" OR "Feeling of security" AND "Qualitative Research" OR "Research Qualitative" OR "qualitative studies" OR "qualitative study" were assessed in the title and abstract of the identified papers. The following research question was also put forth in this review "What is the perception of hospitalized patients about safety?"

Inclusion and Exclusion Criteria

We included published reports of studies of patient's perspective of safety in hospitals and qualitative methods of data collection and analysis (content analysis, thematic analysis, phenomenology, graded theory and, etc.). Articles reporting mixed-methods studies would be included where substantive qualitative findings were presented. The following studies were excluded: quantitative methods, studies not located in hospitals (i.e. primary care, palliative care, home care and …), mixed-methods studies without substantive qualitative findings, different target population (children and teenagers) and systematic review articles. The database search was supplemented by a gray literature search guided by a Google search.

Search Outcomes

The search strategy yielded 13673 unique citations. After abstract screening, 92 studies proceeded to full-text review. A total of 67 studies were excluded for the following reasons: target population (n = 31), quantitative methods (n = 10), different settings (n = 23), and review (n = 3) (Figure 1).

Quality Appraisal

Two authors individually evaluated the study quality using Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) with 10 items (relating to qualitative research design, philosophy and trustworthiness) was used to evaluate quality of the papers [20]. Each question was scored 1 and 0. Studies with a score of 6 and below were excluded from the study.

Copyright ©2022 The Author(s); Published by Advances in Nursing and Midwifery. This is an open access article, distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses /by-nc/4.0/) which permits others to copy and redistribute material just in noncommercial usages, provided the original work is properly cited.

Data Extraction

Based on the PRISMA checklist, data were extracted in two steps [21]. After removing duplicates in the first screening phase, two authors independently reviewed titles and abstracts of the studies. Papers containing full text, were included into the review and were screened separately by two authors. In cases of disagreement between the two authors, the papers were reviewed by the third author. A table was designed in the research team to collect the data from different papers. Data were extracted from all studies: author's name, year of publication, country, title, year of the study, study type, sample and age, data collection procedure and study results.

Synthesis

Data from studies meeting the inclusion criteria were analyzed with concept analysis using of Walker and Avant approach (2011) [22, 23]. At first, each text was read 3 times carefully so that the researcher could extract the key points related to the concept exactly, then attributes, antecedents and consequences were extracted. By integrating the primitive codes based on similarities and differences, sub-categories were created and they were revised after repeated comparison, similar sub-categories were integrated and the main categories were formed.

Ethical Considerations

The permission for conducting the study was obtained from Shahid Beheshti Medical University with code of ethics no.: IR.SBMU.RETECH.REC.1397.1129 .

RESULTS

From a total of 13674 papers which were found until December 2019, 25 papers were finally included in this study. The process of the study selection is shown in Figure 1 (the PRISMA 2009 diagram). The quality assessment tool JBI-QARI had approved all 25 studies. The general characteristics of some of the selected papers (randomly) are given in Table 1.

Table 1. General Characteristics of Some Selected Studies about Feeling of Safety Concept from the Perspective of Patients

Author & year & country	Title	Study Type	Target population & Number	Antecedents	Attributes	Consequences	JBI-QARI score
Hunt 1999 Australia	The cardiac surgical htient3 expectations and experiences of nursing care in the intensive care unit	thematic analysis	patients in ICU.N=12 86-48 years	Vigilance The observant nurse, The nurse's presence, Professionalism, personalized care Communication, Attitude, Caring, care, Unexpected occurrences, Delays, Busy unit, Communication difficulties, Pain, Psychological disturbances	-	-	10
Hupcey 2000 America	Feeling Safe: The Psychosocial Needs of ICU Patients	Grounded theory	ICU patients N=45 (25 to 80 years, with a mean of 59)	**Family and friends,** Someone there, To encourage• To instill hope• To re-orient to outside world• To take care of outside matters• To fill in gaps• To take over medical decisions **ICU staff** • Watch over them• Be there whenever needed• Encourage them to fight• Encourage them to hope• Provide information• Look out for their families **religion**• Faith• Spiritual comfort **Knowing**• listening to the nurses and physicians during rounds• trying to piece together the information• families were the source of this information	**Trusting**• nurses watching over them• meeting or attempting to meet their needs• their full acceptance• without question of the care given	**regaining control**• awaiting heart transplants• rearranged their rooms• controlled visiting times • had special meals • negotiated with the staff about when they would have treatments• taking back some of the responsibilities they had delegated to family members• ambulating **Hoping**• needed to maintain hope to survive• Continual encouragement helped patients maintain hope and fight for survival• Families tried different ways	10
Sue Lasiter2011America	Older adults' perceptions of feeling safe in an intensive care unit	Grounded theory	Older adults (over 65)N=10	**initiative**• ability to get (access) help right now• control (make personal healthcare decisions) **Oversight**• machines checking • nurses checking **Predictability**• Confidence• a high level of education• the ability to recognize problems• quick reaction and response time• knowledge about what to do in an emergency **Proximity**• nurses were close enough to come quickly if needed• having the nurse within sight distance	-	-	**10**
RathertEt al.2011USA	Putting the _patient_ in patient safety: a qualitative study of consumer experiences	grounded theory	Patient with acute and chronic condition and their family(N=Groups ranged in size from 8 to 11, with an average of10 participants)20	**communication** • patient's health status• exchange of information•communicating to patients and family about the general care plan **staffing problems**•incompetent or possibly indolent•system-level issues•understaffing•spend more time on doing paperwork than providing care**medication administration**•concerns	-	-	10

Copyright ©2022 The Author(s); Published by Advances in Nursing and Midwifery. This is an open access article, distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses /by-nc/4.0/) which permits others to copy and redistribute material just in noncommercial usages, provided the original work is properly cited.

			to 69 years, with a mean age of 44 years	regarding the management and distribution of medications •often staff responses left them feeling uncertain about their safety•concerns about medication distribution processes **need for family caregivers as patient advocates**- they may be able to prevent problems			
Vaismoradi et al.2011Iran	Patients' understandings and feelings of safety during hospitalization in Iran: A qualitative study	thematic analysis	patients hospitalized in medical and surgical wards N=19mean age was 49.57 years	-	**from attention to recovery•** patients' dignity • well-being	**becoming hopeful of life•** not to be forgotten • becoming optimistic toward health-care settings **maintaining life routines**-maintain and follow their daily routines-able to remain independent- take part in their own care	**10**
Modig et al.2012Sweden	Frail elderly patients' experiences of information on medication. A qualitative study	content analysis	elderly participants taking cardiovascular medications N=12(aged 68–88)	-	**Comfortable with information•**Trust and confidence•Satisfaction with information•Taking control	**Insecure with information•**Distrust•Deficient information•Lack of availability	**10**10
BROWALLEt al.2013Sweden	Patients' experience of important factors in the healthcare environment in oncology care	Content analysis	patients with different cancer diagnoses in an oncology wardN=1154 years (32_72)	**partnership with the staff•**Being a person•Participation and responsibility•Communication**physical space•**Food and smell•Visual impressions•Surrounding sounds	**Safety•**Continuity and accessibility•Privacy and community	-	10
Bishop and Macdonald2014Canada	Patient Involvement in Patient Safety: A Qualitative Study of Nursing Staff and Patient Perceptions	thematic analysis	Patients in 2 surgical units and 2 medical units N=10Over 18 years	-	**wanting control**-not know enough about their health care-not sharing important information with them **feeling connected-**being friendly-building rapport-spending time with one another-showing respect-sharing information **encountering roadblocks**-care providers were often too busy to answer questions or talk-nurses being in a rush-complain about the system works	**sharing responsibility for safety**-behaviors or actions they took while hospitalized to ensure that they felt safe-asking questions-being engaged when given information-making sure that they had an advocate available to ensure their well-being	**1001**0
Lovink et al.2015Netherlands	Patients' experiences of safety during haemodialysis treatment	content analysis	Patients in haemo dialysis units N= 1239-82 years	**Presence of the nurse:•** were in their close proximity• able to quickly call the nurses • attention from the nurse **Patients' need to control their situation: •** have a high level of knowledge• a great need for information about treatment• monitor their treatment	**Trust in the nurse:•** ability to provide a normal treatment course• help them quickly, adequately and with personal attention• be skilled enough to • professional and responsible • had experience and knowledge	**Physical safety:•** receiving safe treatment by nurses who perform regular checks• not confronted with treatment complications• could depend on a normal and routine treatment course• doctor was available in emergency situations•outlined as prescribing an appropriate treatment (doctor)• qualified dialysis nurse**Emotional safety:•** feeling internally calm during treatment • good communication**physically unsafe:•** coagulation of the dialysis system• bleeding through the vascular access site• (mis)cannulation of the arteriovenous fistula• infection• machine change during treatment• feared not feeling well•durability of their arteriovenous fistula or Tesio-catheter• risks that they had already experienced• being hooked up to the machine and not being able to get away in case of emergencies as threatening• too few nurses• Seeing fellow patients in acute situations• alarms on the machine (solved quickly,	**10**10

Copyright © *2022 The Author(s); Published by Advances in Nursing and Midwifery. This is an open access article, distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses /by-nc/4.0/) which permits others to copy and redistribute material just in noncommercial usages, provided the original work is properly cited.*

						either by the nurses or by the patients themselves)• student dialysis nurse• unconfident nurse (a nurse that acted clumsily or did not appear to know everything)	
Bishop and Cregan2015Canada	Patient safety culture: finding meaning in patient experiences	Thematic analysis	patient and family stories of adverse event experiences were examined N=11	**Passed Around**-gap in the continuity of care- lack of knowledge - being dispersed -hard to engage as member of the health care team-see specialists and doctors playing closer to each other-lack of shared knowledge-feeling of uncertainty -being unaware of the ongoing provider-provider communication **Not Having the Conversation**-hesitant to speak up or felt defeated when they did-not knowing how to say what they needed to communicate-try to bring something to their health care provider's attention-being dismissed by health care providers-feeling of not being heard **the Person Behind the Patient**-sense of losing their identity-need to be cared for and to be treated compassionately-awareness or understanding around each patient's needs-being labeled "difficult" or making assumptions	-	-	**10**
Hågensen et al.2018Norway	The struggle against perceived negligence A qualitative study of patients' experiences of adverse events in Norwegian hospitals	content analysis	former patients recruited by the Health and Social Services ombudsmen N = 15(43-70 years with mean 61 years)	**ignored concerns or signs of complications•**The feeling of something wrong•To speak up•Being ignored/ rejected/ not heard•Falling out of the system (Tries to take care of own body and health, but feels rejected)**lack of responsibility and error correction•** Feeling "life is at stake"•Disclosure, explanation, apology•Feeling avoided•Waiting time•Responsibility•Fault correction (Missed expectations of hospital responsibility and fault correction)**lack of support, loyalty and learning opportunities•** The need of support and understanding• Professional loyalty/ "Cover up" system• Possibility for learning (Needs support, but professional loyalty is more important)	-	-	**10**
New et al.2018Canada	"I just have to take it" – patient safety in acute care: perspectives and experiences of patients with chronic kidney disease	thematic analysis	Patients with CKDN=30Mean 50 years	**Receiving safe care•**Sharing a room with patients on isolation•Roommates perceived to be threatening•Lack of cleanliness•Other patients and visitors**Expecting to be cared for•**Interactions with health care Providers•Trust**Reporting Safety Concerns•**Speaking up•Reactions to questions asked•Awareness of safety line•Using the Safety Line•Lack of trust regarding response to reporting•Fear of reprisal•Added stress with reporting	**Expecting to be taken care of•**Communication amongst providers•Communication between providers and participants•Delays in care	-	10
Gettens et al.2018Australia	The patients' perspective of sustaining a fall in hospital: a qualitative study	phenomenological design	hospital in-patients that had recently fallen N=12(27-84 years)	-	**Realizing the risk**- ask for help-lose confidence in themselves and their ability to remain safe while mobilizing-their bodies not behaving as expected revealing strategies-nurses denied them their independence and their right to make decisions -not being listened to and their opinion was not considered-feel incapable of making decisions-not engaging them with falls prevention	**Feeling safe**-visibility-access to nurses-be physically safe-feel confident that correct procedures were adhered to-not taken as seriously by **Recovering independence and identity**-reduced physical ability to protect themselves from a fall-were at a greater risk of harm-the time when their confidence would return- hospital be delayed for discharge-desire to preserve their dignity	**10**
Asplin et al.2019Sweden	See me, teach me, guide me, but it's up to me Patients'	Content analysis	patients with hip fracture and varying age span N=19mean age	-	**Being seen as a person** •Interaction affects trust and security Information is key to understanding	-	10

Copyright © *2022 The Author(s); Published by Advances in Nursing and Midwifery. This is an open access article, distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses /by-nc/4.0/) which permits others to copy and redistribute material just in noncommercial usages, provided the original work is properly cited.*

	experiences of recovery during the acute phase after hip fracture		82.3 (±8.1) years94-65 years		Encouragement is essential to promote activity **Striving for Independence** Accepting the situation whilst trying to remain positive The greener the better, but it's up to me Ask me, I have goals• Uncertainties concerning future		
Jansson et al.2019Finland	Patients' satisfaction and experiences during elective primary fast-track total hip and knee arthroplasty journey: A qualitative study	content analysis	patients in a single joint replacement center N=2052 to 74 years(mean 66.2)	**patient selection**- indications for surgery and eligibility criteria- delayed due to lack of early diagnose **meeting the Health Care Guarantee**- waiting time- due to lack of anamnestic information- delays - indirect scheduling- need for faster access to healthcare services **patient flow**- pre-operative preparation and the preparations - hospital admission for surgery - discharge from hospital- environmental needs- coordination and continuity of care **post-discharge care**- rehabilitation - recovery - control visit **patient counselling**- implementation - resources - content **transparency of the journey**- minor refinements regarding the status of other joints- surgery techniques- duration, anesthesia and pain management- discharge criteria from recovery room to inpatient care- amount of blood samples taken during inpatient stay- schedule during inpatient stay- rehabilitation- recovery- pain management during post-discharge care- complications **Communication**-patient-clinician communication-information transfer between primary and secondary care- difficulties contacting the right person- calling time was considered too short **Feedback**-giving and receiving feedback- give targeted feedback to each stakeholder- receive feedback from stakeholders	-	-	10
Kaptain et al.2019Denmark	Surgical perioperative pathways—Patient experiences of unmet needs show that a person-centered approach is needed	phenomenological - hermeneutic approach	surgical patients, and patients had many kinds of surgical healthcare needs N=2452.5 years (18-84)	**to know the patient— if they know me, I feel seen and safe**- no one knew their illness story- be prepared for their special needs and illness experiences- frequently kept an eye on-relationship to the healthcare professionals-be present and takes time to welcome the individual patient **communicating with the patient throughout the pathway**- much information to remember -not all patients managed to ask questions- difficult to receive information on the day of surgery-The agreements patients made with healthcare professionals were not always visible - difficult for others to answer their questions-healthcare professionals were based mainly on communication about health **patient - centered pathway is all about organization**- lacked knowledge	-	-	10

Target Population

This study population consisted of both male and female participants of different age groups with a mean age of 62.95 years (18-94). Also, 597 structured and semi-structured interviews were performed in person and 9764 interviews were performed on the phone. The patients were selected from different wards like hemodialysis, medical and surgical, ICU, CCU, delivery room, gynecology, neurosurgery, neurology, and oncology. Most studies were conducted in the USA followed by Sweden, Canada, and Australia, respectively. Besides, of various methods of qualitative studies (phenomenology, grounded theory, hermeneutic, and thematic), conventional content analysis received the greatest share (%37.5).

Data Synthesis

Data analysis resulted finally in eleven main categories: "receiving safe care", "appropriate physical environment", "resorting to spirituality", "having previous negative experiences", and "presence of family

Copyright © *2022 The Author(s); Published by Advances in Nursing and Midwifery. This is an open access article, distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses /by-nc/4.0/) which permits others to copy and redistribute material just in noncommercial usages, provided the original work is properly cited.*

and friends", "Feeling of Protection in a Safe Place", "Emotional Enrichment and Confidence", "Comfort and Tranquility", "Feeling of Control on the Situation", "Optimism towards Life" and "Coping." (Figure 2).

Characteristics and Definition of Feeling of Safety

The term feeling safe is not defined as a phrase in any dictionary references. So, we searched for this purpose in articles.

▪ Feeling safe is an emotional state during which a patient perceives that when confronted with an event, there is no imminent danger of psychological or physical injury [8].

▪ Feeling safe means trust, knowing, control, and hope [10].

▪ It is an emotional state in which the patient feels safe towards care with no feeling of any damage [7].

▪ It means from attention to recovery, becoming hopeful of life, and maintaining life routines [12].

▪ feeling safe from physical or emotional threats (feeling internally calm during treatment sessions and receiving safe treatment) [24].

▪ fulfilled physical, psychological and emotional needs [25].

▪ protecting patients from harm and making feel confident while they are in hospital [26]

▪ Furthermore, some studies have defined feeling of safety as feeling of satisfaction, comfort, and hopefulness [10, 24, 27].

Antecedents

The antecedents obtained in review of literature were the categories "receiving safe care", "appropriate physical environment", "resorting to spirituality", "having previous negative experiences", and "presence of family and friends ."

1. Having Previous Negative Experiences

These experiences with their important role in patient's feeling toward the healthcare team include "negative experience in communicating with personnel" [11, 14], "experience of receiving ineffective care" [8, 9, 11, 13, 14, 25, 28-31], "experience of lack of support and understanding" [11, 31], and "lack of possibility of criticizing the personnel" [11, 32]. In other words, negative experiences consist of all events experienced by the patient during their previous communication with the treatment staff. Most of these negative experiences were created following the healthcare team's inability to communicate properly with the patients.

1.1. Experience of receiving ineffective care: Ineffective care refers to provision of care by the staff that lack knowledge and skills, frequent occurrence of errors, lack of respect for the patient, lack of patient's contribution, lack of observing patient privacy, inappropriate inter-personnel communication, inappropriate communication of the treatment team with the patient, long waiting time for receiving services, delay in diagnosis and care, and a gap in continuation of care [8, 9, 11, 13, 14, 25, 28-31].

1.2. Experience of lack of support and understanding: The patients need to be understood and supported by the treatment team, especially by the physicians and nurses. They do not want to feel that they are left alone in the ward with their problems. Even provision of a little information on their disease can create feelings of support in them [11]. Sometimes, various medical errors occur in the treatment settings that are discovered and reported by the knowledgeable patient. In this case, the patient anticipates to be supported by other members of the treatment team and be assured that the problem will not be repeated again [31].

Table 2. Categories and Subcategories Related to "Receiving Safe Care"

Main Category/Categories /Subcategories
Receiving safe care
experienced personnel
Knowledge
Skill
Competence
Responsible
Sufficient supervision
Responsive
Suitable and efficient communication
Support
Presence
Continuity of care
Honesty
Professional behavior
Coordination of the treatment team
Coordination among the patients, their families, and treatment team
Proper contribution of the physicians and nurses
Correspondence of standards to care
Patient-centered care
Patient contribution to care
Giving feedback to patient
Paying attention to patient's attitude
Observing patient privacy
Maintaining patient's personal position

2.2. Coordination of the treatment team: This refers to "coordination among the patients, their families, and treatment team", "proper contribution of the physicnas and nurses", and "correspondence of standards to care". Patients and their families expect the treatment team to devote a greater time to them since they demand more information on their disease and the course of their treatment and improvement [29, 33]. The patients stated that they had many questions to ask the physicians and nurses; yet, it was not possible for them due to limited communication and poor coordination between physicians and nurses [33]. One of the important causes of this problem was inappropriate transmission of information from physicians to nurses [13]. Sometimes, the patient is located in a situation wherein they are made compare the given care to

Copyright ©2022 The Author(s); Published by Advances in Nursing and Midwifery. This is an open access article, distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses /by-nc/4.0/) which permits others to copy and redistribute material just in noncommercial usages, provided the original work is properly cited.

standards. Lack of correspondence between given care and standards or contradiction between the two may negatively affect this coordination [30].

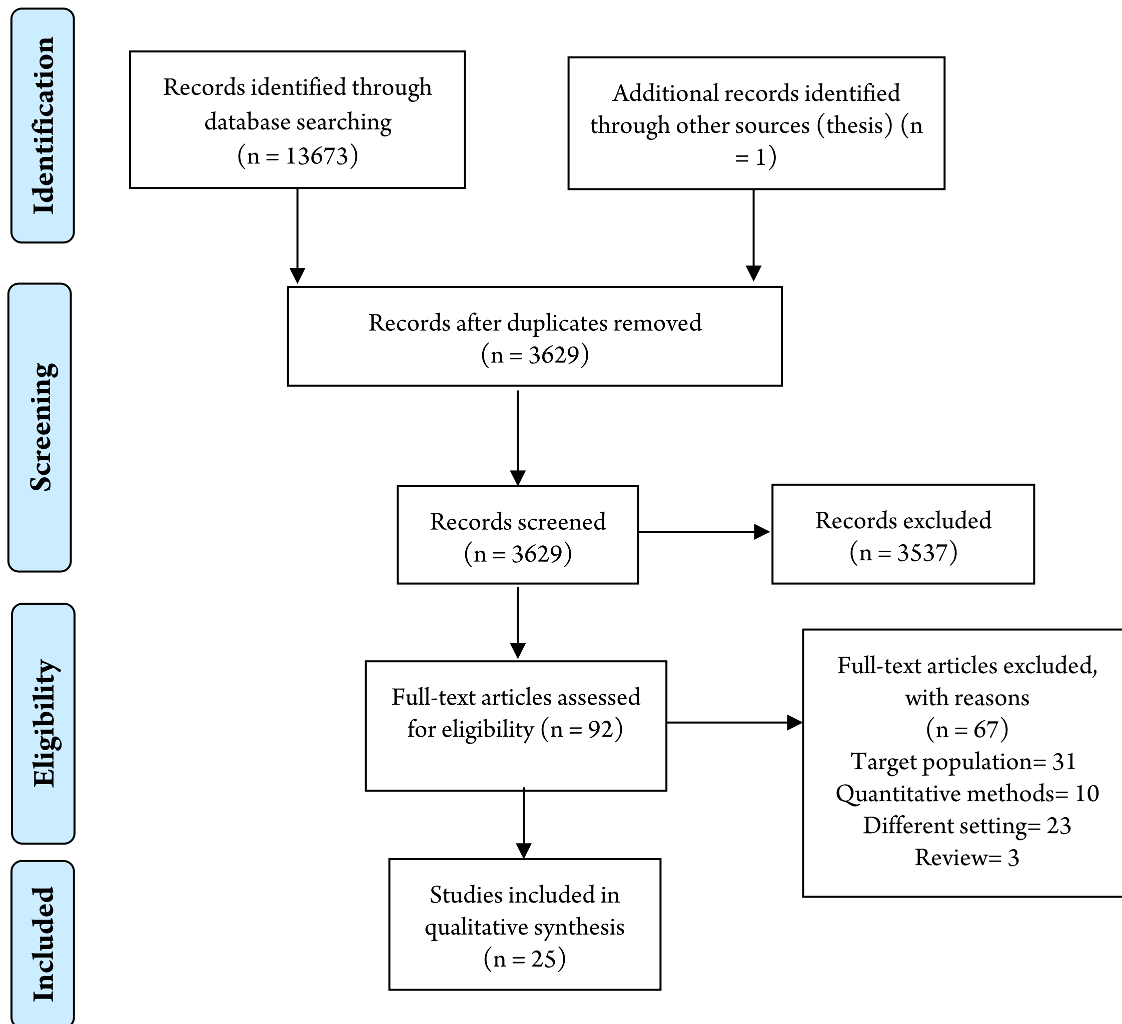

Figure 1. PRISMA diagram for the selection of studies

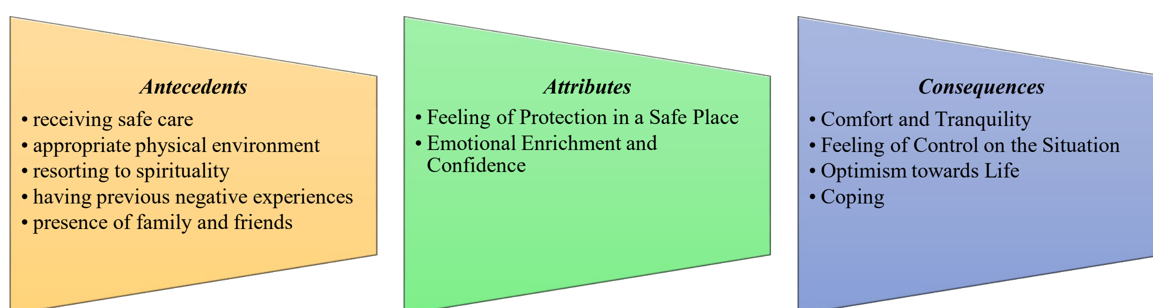

Figure 2. Antecedents, attributes and consequences of "feeling safe"

1.3. Lack of possibility of criticizing the personnel: The patient expects to criticize the personnel following provision of ineffective care by the treatment team such as painful procedures, inattention to patient's signs and symptoms, etc. and provide them with some feedback; nonetheless, the personnel's inappropriate feedback makes the patients feel that they are not important to the personnel and that the focus is on care provision without considering the patients [11].

2. Receiving Safe Care

This refers to "experienced personnel", "coordination of the treatment team", and "patient-centered care" (Table 2).

2.1. Experienced personnel: In patient's perspective, for the treatment team to be skilled and knowledgeable,

Copyright ©2022 The Author(s); Published by Advances in Nursing and Midwifery. This is an open access article, distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses /by-nc/4.0/) which permits others to copy and redistribute material just in noncommercial usages, provided the original work is properly cited.

they should possess features such as sufficient knowledge, skill in performing procedures and the required competency [6, 9, 12, 15, 24]. They ought to be responsible for patient needs and be present at patient's bedside to be able to support the patient [6, 29, 34]. The staff will provide continual and effective care for the patient through establishing suitable and efficient communication [29, 35]. Along with these characteristics, honesty with the patient and professional behavior like respecting the patient are of importance [12, 35, 36].

2.3. Patient-centered care: This category consists of the subcategories "patient contribution to care", "giving feedback to patient", "paying attention to patient's attitude", "observing patient privacy", and "maintaining patient's personal position". Patient-centered care is a type of care in which the patient contributes to decision-makings on care-giving and is informed completely of the care and treatment course. In other words, the patient is at the center of care-giving [12, 33, 35, 37]. Besides, the patient gives purposeful feedback to the treatment team and, in turn, they receive feedback from the patient regarding the provided care and treatment. In this type of care-giving, the treatment team does not overlook the patient's attitude and pay due attention to patient's reaction to various care issues [29, 35]. The patients want to have a private room and sufficient space for meeting family and friends. Inappropriate physical space made them feel that due attention is not paid to their privacy [35].

3. Appropriate Physical Environment

This refers to "up-to-date technology", "sufficient facilities", "proper hygiene and sanitation", and "appropriate nutritional status". The patients need to be cared for in a care setting with suitable and up-to-date technology and standards, and sufficient facilities such as a TV set, clothes, sheets, etc. [8, 13]. Proper hospital sanitation refers to sufficient lighting in the hospital, proper humidity, suitable ventilation and temperature, proper designing of the wards, absence of noise pollution, and cleaning of the setting [8, 12, 13, 35]. Moreover, in an appropriate nutritional status, the food enjoys variety in items, good quality and taste, and even the right of choosing food items for patients [35].

4. Resorting to Spirituality

Religion and performing religious rituals and ceremonies are important and influential factors in creating hope in patients, especially ICU patients and their role cannot be ignored. The patients stated that they gained spiritual comfort and tranquility through performing religious ceremonies and saying prayers [10].

5. Presence of Family and Friends

Many studies had referred to the effects of the presence of family and friends on patient safety. Family and friends create feeling of safety in the patient via "giving hope", "encouraging the patient", transmitting information to the patient", and "contribution to care" [10, 33, 34]. The patient demands that important individuals be present at their bedside and contribute to their treatment to make them optimistic towards their treatment. In patient's perspective, the family can defend their rights by their presence preventing many of the problems related to patient safety [38].

Attributes

The Attributes obtained in review of literature were the categories "Feeling of Protection in a Safe Place", "Emotional Enrichment and Confidence" (Figure 2).

1. Feeling of Protection in a Safe Place

This refers to patient protection against care-related hurts, damages, and medical errors [24, 26]. Thus, prompt presence of sufficient number of knowledgeable physicians and nurses on patient's bedside to perform correctly the care-giving and treatment procedures is of utmost significance to ward off occurrence of any medical errors [8, 24, 26, 31].

2. Emotional Enrichment and Confidence

This category includes subcategories: "personnel's attention to patient's emotional needs", "personnel's positive emotional reactions", and "confidence in the treatment team".

2.1. Attention to patient's emotional needs: Securing the emotional needs of the patient plays a significant role in their compatibility with the disease and managing the created challenges in the care setting [12]. These needs include feeling of confidence, worthiness, kindness towards the patient (sympathy), and establishing none-care communication not aimed at care-giving [10, 31, 35, 36].

2.2. Personnel's positive emotional reactions: This refers to paying attention to the patient, answering the patient's questions, and looking at the patient as a human [6, 15, 25, 34, 35]. These positive reactions can create feelings of self-esteem and respect in the patient [12, 26, 36].

2.3. Confidence in the treatment team:

When the treatment team allows the patient to contribute to care-giving, provides the patient with the required information, and prepares all the conditions needed for an effective care-giving, especially when they inform the patient of all treatment processes, the patient confides in them. As a result, they will have no doubt in the quality and type of care given by the personnel. For example, the patient asks the personnel no question on the type of care given and is sure that they do their job accurately [10, 24, 27, 34, 39].

Consequences:

Copyright © *2022 The Author(s); Published by Advances in Nursing and Midwifery. This is an open access article, distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses /by-nc/4.0/) which permits others to copy and redistribute material just in noncommercial usages, provided the original work is properly cited.*

The Consequences obtained in review of literature were the categories "Comfort and Tranquility", "Feeling of Control on the Situation", "Optimism towards Life" and "Coping" (Figure 2).

1. Comfort and Tranquility

One of the important consequences of feeling of safety is comfort and tranquility created by patient's satisfaction with the performance of the treatment team and hopefulness (optimism) [24, 27].

"Patients who described safety in emotional terms expressed feeling internally calm during treatment sessions" [24].

2. Feeling of Control on the Situation

Another important consequence is feeling of control and independence created in the patient following feeling of ability. This feeling, indeed, helps the individual to become aware of themselves as a unique individual resulting in their greater efforts for maintaining control [11, 12]. In this case, the patient tries to acquire control and the natural course of their life. For instance, they try to contribute to care decision-makings, regulate their visit time, talk to the staff, and control the environmental factors to some degree [6, 10, 12, 24, 26, 29, 35, 37, 40].

3. Optimism towards Life

After giving hope to the patient by the staff and family through talking, encouraging, reminding of goals, and visiting important persons in life, the patient becomes optimistic towards treatment course and improvement and finally, towards their life [10, 12, 39].

4. Coping

This is one of the important categories referred to in some studies. This attribute explains how the patient seeks hopefulness (optimism) towards their treatment following compatibility (coping) with the present conditions. Indeed, they try to acquire some mechanisms for controlling and maintaining their ADL (activities of daily living) [12, 37].

Finally, "feeling of safety" may be defined in this way on the basis of review:

"Feeling of safety is perceived as both feeling of protection in a safe place and emotional enrichment and confidence with the prerequisites of receiving safe care, appropriate physical environment, resorting to spirituality, absence of previous negative experiences (having positive experiences), and presence of family and friends resulting in comfort and tranquility, coping, feeing of control on the situation, and optimism towards life".

DISCUSSION

This study aimed at a systematic review of the qualitative studies related to meaning and definitions of feeling of safety in patient's perspective and experiences during their hospital stay and identifying its antecedents and consequences. The final analysis of data collected in review of literature resulted in the categories "having negative previous experiences", "receiving safe care", "appropriate physical environment", "resorting to spirituality", "presence of family and friends", "feeling of protection in a safe place", "emotional enrichment and confidence", "comfort and tranquility", "having control on the situation", "coping", and "optimism towards life". "Receiving safe care" was one of the main categories mentioined by many studies. It is a kind of comprhensive patient-centered care in which the treatment team posesses sufficient skill and knowledge [6, 9, 12, 15, 24]. In addition to sufficient competency and professionalism in care-giving and treatment, other attributes such as honesty and profesional ethics are important [12, 35, 36]. The patient expects the treatment team to make a suitable rapport with them corresponding to their status and thereby maintaining their self-esteem and dignity [12, 26, 36]. They expect to receive sufficient information on the type of care given. Nevertheless, some studies highlighted that excess information was stressful to the patient [27]. Consequently, receiving sufficient information at appropriate times is of utmost significance [15, 34]. It appears that few studies have so far focused on the rate of awareness of the treatment team of the amount of information given to the patient and method of giving it. The studies had just referred to the method of information transmission.

The role of family and friends in supporting the patient and helping them to adjust themselves to conditions and the changes created is undeniable. The family helps the patient to tolerate the hospital stay more easily through provision of information, encouraging and giving hope, enabling them to pass the recovery period in higher spirits. Also, the family plays the role of coordinator between the treatment team and the patient [10, 33, 34]. Faith and resorting to spirituality had created spiritual tranquility in patients [10]. The patients will reinforce feeling of optimism in them via saying prayers. It seems that this category finds greater meaning in ICU and with chronically ill patients; yet, few studies have dealt with this concept. Nevertheless, what is crystal-clear is the role of spirituality in creating tranquility in patients. Numerous studies have dealt with the role of spirituality in various groups of patients such as cancer patients and creation of hope in them. However, more future studies are required to detect the mechanisms used by patients to achieve spiritual tranquility or the conditions under which patients resort to religiosity and spirituality. All of the mentioned factors will ultimately result in patient's greater feeling of safety during hospital stay. This feeling is a basic need the prerequisites of which are discovered by the use of various environmental and humanistic factors in the mentioned studies while some factors still remain unknown. The meaning of safety is much wider than security. In addition to the physical aspects, it

Copyright © *2022 The Author(s); Published by Advances in Nursing and Midwifery. This is an open access article, distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses /by-nc/4.0/) which permits others to copy and redistribute material just in noncommercial usages, provided the original work is properly cited.*

entails the emotional and spiritual aspects referred to as feeling of emotional safety and confidence in the mentioned studies [8, 10, 24, 27, 34, 39]. Yet, previous studies have dealt with it very sporadically. Feeling of emotional safety (emotional enrichment and confidence), with its intellectual and mental state, ought to include a wider spectrum of subcategories and codes. Additionally, the subcategories have not been very clarifying and elucidating regarding this category. Many studies have extensively explored physical safety that is synonymous with security [8, 24, 26]. Some factors like the patient's previous negative experiences would confound this feeling. These confounding factors can influence patient's feeling of safety [8, 9, 11, 13, 14, 25, 28-31].

Removal of the confounding factors, securing care needs, and presence of family and relatives may induce feeling of tranquility in the patient resulting in their satisfaction with the healthcare system and coping with the conditions [12, 37]. Tranquility, coping, optimism, and feeling of control of the situation are consequences of feeling of safety. Yet, the important point to be noted is the high degree of overlap between attributes and consequences of patient's feeling of safety. Future studies should focus on defining feeling of safety and its consequences to determine the border between them since finding this border was very difficult and confusing in the present study. Moreover, these studies have not referred to coping mechanisms used by the patient, for example, the mechanisms used by the patient to cope with the present condition or what coping skills they will use in the case of lack of compatibility (coping).

Compared to other studies, in this study, an attempt was made to use a wider spectrum of pertinent key words to search in multiple databases without any time or language limitations (without any selection or publication bias). Also, screening of literature was completed by two separate researchers not to lose any study. Yet, there were not more chances of further databases for the researchers that might have limited the search scope.

CONCLUSION

Our findings suggested that patient safety is perceived during hospital stay as both feeling of protection in a safe place and emotional enrichment and confidence with the prerequisites of safe care, appropriate physical environment, resorting to spirituality, absence of negative previous experiences (having positive experiences), and presence of family and friends predisposing to tranquility, coping and compatibility, feeling of control on the situation, and optimism towards life. Safe care is one of the fundamental needs in creating feeling of safety in patients. Focusing on this type of patient-centered care may promote quality care and improve the treatments provided in the hospital setting.

ACKNOWLEDGMENTS

This study was extracted from the PhD dissertation (no.: 1397.1129) of the first author and financially supported by Shahid Beheshti University of Medical Sciences. The authors would like to acknowledge all the participants whose contribution enabled the production of this paper.

FUNDING

The study has no funding.

ETHICAL CONSIDERATION

The authors of the present study tried to use the results reported in each article correctly and avoid putting their personal ideas. The study has been registered with ethical code: IRSBMU.PHNM1397-1129

CONFLICTS OF INTEREST

The authors declare that there is no conflict of interest.

AUTHORS' CONTRIBUTION

The first author: study design, data collection and drafting the manuscript. Corresponding author: did supervision, Study design, drafting, revising the manuscript. The third author: study design and advisor. The fourth author: did data analysis.

REFERENCES

1. Shali M, Joolaee S, Hooshmand A, Haghani H, Masoumi H. The Relationship between Incidence of Patient Falls and Nurses' Professional Commitment. J hayat. 2016;22(1):27-37.
2. Dehghan Nayeri N, Arab Ameri Z, Seylani K. Patient's Safety during Blood Transfusions in Hospitals Affiliated with Tehran University of Medical Sciences. Iran J Nurs. 2016;28(98):39-49. **doi:** 10.29252/ijn.28.98.39
3. Mhammadi E. The issue of patient safety in psychiatric wards and center: a systematic review. Iran J Sys Rev Med Sci. 2017;1(1):21-35.
4. Improving Patient Safety in Hospitals. A Resource List for Users of the AHRQ Hospital Survey on Patient Safety Culture 2020. Available from: www.ahrq.gov/qual/patientsafetyculture.
5. Ricci-Cabello I, Pons-Vigues M, Berenguera A, Pujol-Ribera E, Slight SP, Valderas JM. Patients' perceptions and experiences of patient safety in primary care in England. Fam Pract. 2016;33(5):535-42. **doi:** 10.1093/fampra/cmw046 **pmid:** 27312563
6. Lasiter S. Older adults' perceptions of feeling safe in an intensive care unit. J Adv Nurs. 2011;67(12):2649-57. **doi:** 10.1111/j.1365-2648.2011.05714.x **pmid:** 21645044
7. Mollon D. Feeling safe during an inpatient hospitalization: a concept analysis. J Adv Nurs. 2014;70(8):1727-37. **doi:** 10.1111/jan.12348 **pmid:** 24383463
8. Russell S. An exploratory study of patients' perceptions, memories and experiences of an intensive care unit. J Adv Nurs. 1999;29(4):783-91. **doi:** 10.1046/j.1365-2648.1999.00953.x **pmid:** 10215968
9. Hunt JM. The cardiac surgical patient's expectations and experiences of nursing care in the intensive care unit. Aust Crit Care. 1999;12(2):47-53. **doi:** 10.1016/s1036-7314(99)70535-7 **pmid:** 10624186

Copyright © *2022 The Author(s); Published by Advances in Nursing and Midwifery. This is an open access article, distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses /by-nc/4.0/) which permits others to copy and redistribute material just in noncommercial usages, provided the original work is properly cited.*

10. Hupcey JE. Feeling safe: the psychosocial needs of ICU patients. J Nurs Scholarsh. 2000;32(4):361-7. **doi:** 10.1111/j.1547-5069.2000.00361.x **pmid:** 11140200
11. Nilsson C. The delivery room: is it a safe place? A hermeneutic analysis of women's negative birth experiences. Sex Reprod Healthc. 2014;5(4):199-204. **doi:** 10.1016/j.srhc.2014.09.010 **pmid:** 25433832
12. Vaismoradi M, Salsali M, Turunen H, Bondas T. Patients' understandings and feelings of safety during hospitalization in Iran: a qualitative study. Nurs Health Sci. 2011;13(4):404-11. **doi:** 10.1111/j.1442-2018.2011.00632.x **pmid:** 21883768
13. Lee AV, Moriarty JP, Borgstrom C, Horwitz LI. What can we learn from patient dissatisfaction? An analysis of dissatisfying events at an academic medical center. J Hosp Med. 2010;5(9):514-20. **doi:** 10.1002/jhm.861 **pmid:** 21162153
14. Bishop AC, Cregan BR. Patient safety culture: finding meaning in patient experiences. Int J Health Care Qual Assur. 2015;28(6):595-610. **doi:** 10.1108/IJHCQA-03-2014-0029 **pmid:** 26156433
15. Kaptain K, Ulsoe ML, Dreyer P. Surgical perioperative pathways-Patient experiences of unmet needs show that a person-centred approach is needed. J Clin Nurs. 2019;28(11-12):2214-24. **doi:** 10.1111/jocn.14817 **pmid:** 30786078
16. Wassenaar A, Schouten J, Schoonhoven L. Factors promoting intensive care patients' perception of feeling safe: a systematic review. Int J Nurs Stud. 2014;51(2):261-73. **doi:** 10.1016/j.ijnurstu.2013.07.003 **pmid:** 23910399
17. Daker-White G, Hays R, McSharry J, Giles S, Cheraghi-Sohi S, Rhodes P, et al. Blame the Patient, Blame the Doctor or Blame the System? A Meta-Synthesis of Qualitative Studies of Patient Safety in Primary Care. PLoS One. 2015;10(8):e0128329. **doi:** 10.1371/journal.pone.0128329 **pmid:** 26244494
18. Kim L, Lyder CH, McNeese-Smith D, Leach LS, Needleman J. Defining attributes of patient safety through a concept analysis. J Adv Nurs. 2015;71(11):2490-503. **doi:** 10.1111/jan.12715 **pmid:** 26122016
19. Moher D, Liberati A, Tetzlaff J, Altman DG, Group P. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. Int J Surg. 2010;8(5):336-41. **doi:** 10.1016/j.ijsu.2010.02.007 **pmid:** 20171303
20. Institute JB. The Joanna Briggs Institute. Joanna Briggs Institute Reviewers' Manual: 2014 edition. The Joanna Briggs Institute.2014.
21. Moher D, Liberati A, Tetzlaff J, Altman DG, Group P. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. Ann Intern Med. 2009;151(4):264-9, W64. **doi:** 10.7326/0003-4819-151-4-200908180-00135 **pmid:** 19622511
22. Schwartz-Barcott D. An expansion and elaboration of the hybrid model of concept development. Concept Development in Nursing Foundations, Techniques, and Applications.2000. 129-59 p.
23. Walker LO, Avant KC. Strategies for theory construction in nursing.2005.
24. Lovink MH, Kars MC, de Man-van Ginkel JM, Schoonhoven L. Patients' experiences of safety during haemodialysis treatment--a qualitative study. J Adv Nurs. 2015;71(10):2374-83. **doi:** 10.1111/jan.12690 **pmid:** 26013601
25. New L, Goodridge D, Kappel J, Groot G, Dobson R. "I just have to take it" - patient safety in acute care: perspectives and experiences of patients with chronic kidney disease. BMC Health Serv Res. 2019;19(1):199. **doi:** 10.1186/s12913-019-4014-4 **pmid:** 30922299
26. Gettens S, Fulbrook P, Jessup M, Low Choy N. The patients' perspective of sustaining a fall in hospital: A qualitative study. J Clin Nurs. 2018;27(3-4):743-52. **doi:** 10.1111/jocn.14075 **pmid:** 28926152
27. Modig S, Kristensson J, Troein M, Brorsson A, Midlov P. Frail elderly patients' experiences of information on medication. A qualitative study. BMC Geriatr. 2012;12:46. **doi:** 10.1186/1471-2318-12-46 **pmid:** 22909093
28. Burgess C, Cowie L, Gulliford M. Patients' perceptions of error in long-term illness care: qualitative study. J Health Serv Res Policy. 2012;17(3):181-7. **doi:** 10.1258/JHSRP.2012.011122 **pmid:** 22807556
29. Jansson MM, Harjumaa M, Puhto AP, Pikkarainen M. Patients' satisfaction and experiences during elective primary fast-track total hip and knee arthroplasty journey: A qualitative study. J Clin Nurs. 2020;29(3-4):567-82. **doi:** 10.1111/jocn.15121 **pmid:** 31769559
30. Howard M, Fleming ML, Parker E. Patients do not always complain when they are dissatisfied: implications for service quality and patient safety. J Patient Saf. 2013;9(4):224-31. **doi:** 10.1097/PTS.0b013e3182913837 **pmid:** 24257066
31. Hagensen G, Nilsen G, Mehus G, Henriksen N. The struggle against perceived negligence. A qualitative study of patients' experiences of adverse events in Norwegian hospitals. BMC Health Serv Res. 2018;18(1):302. **doi:** 10.1186/s12913-018-3101-2 **pmid:** 29699556
32. Nilsson C, Lundgren I. Women's lived experience of fear of childbirth. Midwifery. 2009;25(2):e1-9. **doi:** 10.1016/j.midw.2007.01.017 **pmid:** 17512645
33. Jeffs L, Kitto S, Merkley J, Lyons RF, Bell CM. Safety threats and opportunities to improve interfacility care transitions: insights from patients and family members. Patient Prefer Adherence. 2012;6:711-8. **doi:** 10.2147/PPA.S36797 **pmid:** 23055704
34. Asgari MR, Mohammadi E, Khoshknab MF, Tamadon MR. Hemodialysis patients' perception from nurses' role in their adjustment with hemodialysis: A qualitative study. Koomesh. 2011;12(4).
35. Browall M, Koinberg I, Falk H, Wijk H. Patients' experience of important factors in the healthcare environment in oncology care. Int J Qual Stud Health Well-being. 2013;8:20870. **doi:** 10.3402/qhw.v8i0.20870 **pmid:** 23924604
36. Bishop AC, Macdonald M. Patient Involvement in Patient Safety: A Qualitative Study of Nursing Staff and Patient Perceptions. J Patient Saf. 2017;13(2):82-7. **doi:** 10.1097/PTS.0000000000000123 **pmid:** 25010194
37. Andersson L, Burman M, Skar L. Experiences of caretime during hospitalization in a medical ward: older patients' perspective. Scand J Caring Sci. 2011;25(4):646-52. **doi:** 10.1111/j.1471-6712.2011.00874.x **pmid:** 21371071
38. Rathert C, Brandt J, Williams ES. Putting the 'patient' in patient safety: a qualitative study of consumer experiences. Health Expect. 2012;15(3):327-36. **doi:** 10.1111/j.1369-7625.2011.00685.x **pmid:** 21624026
39. Asplin G, Carlsson G, Fagevik Olsén M, Zidén L. See me, teach me, guide me, but it's up to me! Patients' experiences of recovery during the acute phase after hip fracture. Europe J Physiother. 2019. **doi:** 10.1080/21679169.2019.1650394
40. Bibeau AM. Interventions during labor and birth in the United States: a qualitative analysis of women's experiences. Sex Reprod Healthc. 2014;5(4):167-73. **doi:** 10.1016/j.srhc.2014.10.003 **pmid:** 25433825

Copyright © *2022 The Author(s); Published by Advances in Nursing and Midwifery. This is an open access article, distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses /by-nc/4.0/) which permits others to copy and redistribute material just in noncommercial usages, provided the original work is properly cited.*