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# AND THE SURVEY SAYS ... A QUALITATIVE EXPLORATION OF STRUCTURATIONAL DIVERGENCE FROM THE PERSPECTIVES OF NURSE MANAGERS WHO ARE ACCOUNTABLE FOR PATIENT EXPERIENCE MEASURES

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DISSERTATION

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A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Communication and Information
at the University of Kentucky

By

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ABSTRACT OF DISSERTATION

# AND THE SURVEY SAYS …: A QUALITATIVE EXPLORATION OF STRUCTURATIONAL DIVERGENCE FROM THE PERSPECTIVES OF NURSE MANAGERS WHO ARE ACCOUNTABLE FOR PATIENT EXPERIENCE MEASURES

For more than a decade, hospital leaders have focused on boosting patient experience scores as part of the federal government's value-based purchasing (VBP) program. Hospitals that receive federal financial assistance (such as Medicare) are mandated to participate in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a standardized survey that measures patients' perceptions of their care. Results are publicly reported, and hospitals may be penalized on their reimbursements if they do not reach established benchmarks for patient experience. However, much debate has occurred about whether VBP has increased the quality of healthcare and whether the HCAHPS is an accurate measure of patient experience. Nurse managers on inpatient hospital units are, for their part, the ones held accountable for their units' patient experience scores, which are scores that they often cannot control. This dissertation project is a qualitative exploration of how such accountability impacts nurse managers. With structurational divergence theory (SDT) as a framework, the study seeks to gain a deeper understanding about gridlock that exists and the resulting negative spirals of communication that occur when patient experience expectations by hospital leaders conflict with the needs of nurses on the frontline. Findings of this research suggest that the pressure to earn optimal patient experience scores is, by and large, a source of stress to inpatient nurse managers. Furthermore, findings reveal that opportunities exist within hospital organizations to enhance communication processes about patient experience, with the overarching finding being a need to better communicate to frontline staff the "why" behind the rationale for working toward patient experience goals. Also, findings indicate that expectations by hospital senior leaders to meet established patient experience goals can create conflict for nurse managers who are often caught in the middle between satisfying organizational goals and tending to the needs of frontline staff. Such conflict can spur a reactive work approach that is task-oriented and impedes the visualization of patient experience as a holistic concept. Several recommendations are offered to address issues from macro (policy), meso (organizational), and micro (nurse manager) levels. Additionally, this dissertation proposes an expansion to SDT. Ultimately, the research deduces that hospital

organizations should work toward a more holistic consideration of patient experience, in lieu of an intense focus on patient experience metrics. This includes honing mutual understanding and embracing communication processes that will facilitate collaboration, rather than polarization, among organizational structures.

KEYWORDS: HCAHPS, patient experience scores, nurse manager communication, nurse manager accountability, structurational divergence theory, hospital organizational communication.

Lisa Carpenter Huddleston

September 1, 2023

# AND THE SURVEY SAYS . . .: A QUALITATIVE EXPLORATION OF STRUCTURATIONAL DIVERGENCE FROM THE PERSPECTIVES OF NURSE MANAGERS WHO ARE ACCOUNTABLE FOR PATIENT EXPERIENCE MEASURES

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DEDICATION

To my husband, Edward Huddleston, for the unconditional love you have provided me for more than 33 years, and for your perpetual support of all my dreams and aspirations—no matter how crazy or lofty they may seem!

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When I embarked upon on this adventure in August 2019, I never imagined what a wild ride it would be. This dissertation is the culmination of many years of hard work, sweat, and at times tears. Although traveling this path has been my journey alone—one that has taken much heart and courage—getting to the destination would not have been possible without the support, encouragement and expertise of a host of mentors and loved ones alike. Thus, I'd like to recognize a few individuals who have provided insight and direction to help me to the finish line.

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# CHAPTER ONE: INTRODUCTION

From the time I was a small girl watching my mother go to work as a nurse (and then later on as a nurse leader), I have always felt that nursing is a noble profession. Since Florence Nightingale pioneered modern nursing in the nineteenth century, the profession has benefited from generations of faithful servants who have been called to care for the health and well-being of their fellow human beings. To this day nurses are critical for ensuring the optimal health and well-being of society. This is increasingly evident in this era of COVID-19. For going on four years, the pandemic has highlighted the essential role that nurses play. Furthermore, it has magnified and further strained a problem that existed pre-pandemic—one where there are simply not enough nurses to meet current demand.

Although there has been a significant inflow of nurses in the nation's workforce since the recession of 2008, the shortage is projected to only get worse throughout the next decade (Zhang et al., 2018). In fact, by 2030 Zhang and associates (2018) calculate a national shortage of approximately a half million nurses. This shortage is due, in part, to an increase in demand for healthcare services by an aging Baby Boom generation (American Nurses Association, 2020) and the fact that Baby Boom-era nurses are retiring themselves. Specifically, more than 20% of all nurses in the U.S. plan to retire within the next few years (National Nursing Workforce Survey, 2020), or about 70,000 nurses annually (Warshawsky & Cramer, 2019).

In addition to supply not meeting demand, the current low national unemployment rate has resulted in competing industries seeking out a younger generation of workers who might otherwise consider nursing as a profession (Zhang et al., 2018). A shortage of

nurse educators is also a factor (Haddad, 2022). Furthermore, Haddad and associates (2022) contend that many nurses entering the workforce leave nursing early, determining that the profession is not what they thought it would be, perhaps due in part to immense workplace stress and burnout. Without question, nurses' workplace challenges are abundant, as they commonly endure significant stress in what is an overburdened health care system (American Nurses Association, 2020), one where the COVID-19 pandemic has stretched already limited resources even thinner.

Considering the stress that today's nurses endure, it stands to reason that nurse leaders, particularly nurse managers who manage frontline nurses in hospitals, are also overwhelmed. For their part, hospital nurse managers juggle a multitude of responsibilities that create significant stressors, including role overload, role ambiguity, and role conflict (Kath et al., 2013). Nurse managers encounter challenges due to limited staffing and resources from resulting hospital financial cutbacks over the years. On top of that, their roles necessitate additional managerial responsibilities that not only include hiring, firing, conducting performance evaluations, and attending meetings, but also mediating interpersonal conflicts among staff and addressing patient and family complaints (Dunham-Taylor, 2013).

Furthermore, with Baby Boom nurse managers retiring (Warshawsky & Cramer, 2019), those younger generations who might replace them are avoiding managerial roles. Thus, attributing nurse manager shortages solely to the retirement of Baby Boomers is not an accurate assessment (Keith et al, 2021). Younger nurses are taking on other career choices, as taking on a nurse manager role is just "too much work, taking up too much time, without appropriate financial compensation" (Dunham-Taylor, 2013, p. 35).

Saifman and Sherman (2019) concur that the development and retention of younger nurse managers can be challenging. Their qualitative exploration of Millenial nurse managers revealed that for effective leadership succession to occur, more proactive (rather than reactive) development of capable young leaders is necessary. Additionally, they assert that the recruitment of younger nurses into management roles will require consideration of organizational factors that are important to the younger generations (Faller & Gogek, 2019). This includes strong social relationships with staff and more manageable work-life balances (Christensen et al., 2018; Faller & Gogek, 2019).

Dunham-Taylor (2013) adds that although much of nurse managers' work entails managing common-day challenges related to limited staffing and resources, they are also expected to meet performance standards from pay-for-performance mandates that, if not met, will result in reduced insurance payments (particularly Medicare reimbursements) for their organizations. These performance outcomes, which serve as an additional stressor for nurse managers, not only include operational efficiencies and patient safety but also patient experience—that is, how patients themselves define their own perceptions of the care they received.

## Relevance of the Patient Experience and Its Measures

The Beryl Institute, formed in 2010, is a global community of healthcare professionals and experience champions committed to transforming the human experience in healthcare. This organization defines the patient experience as "the sum of all interactions, shaped by an organization's culture, that influence patient perceptions, across the continuum of care" (Wolf et al., 2014). For more than a decade, perspectives of healthcare among health organizations have evolved to include consideration of the

patient experience. Patients, for their part, do not want to be treated by their healthcare providers as broken parts but as unique human beings who have a desire for their providers to be interested in personal aspects of their lives beyond their medical conditions (Zimmerman et al., 2020). Moreover, Wolf (2018) found that healthcare consumers most wanted to be listened to, to receive clear explanations, and to be treated with courtesy and respect.

Numerous studies indicate that as patients' perspectives of their experiences improve, so does the quality of care they receive and their ultimate health outcomes (Luxford & Sutton, 2014). Thus, an increased focus on the patient experience is warranted. However, much debate has and still occurs over how to best measure the patient experience, as well as who should be accountable for these measures (Dempsey et al., 2014; Segon et al., 2020; Vyas et al., 2022). Currently, the primary measure of patient experience within hospitals is the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a standard survey developed by the federal government and mandated by the Centers for Medicare and Medicaid Services (CMS). Survey results account for 25% of value-based purchasing (VBP) scores and incentive payments (Dempsey et al, 2014). Hospitals that do not meet established benchmarks set by the government can be penalized up to 2% of their Medicare reimbursement (CMS, 2023a).

For their part, standardized measurement structures such as HCAHPS have helped to sharpen focus and facilitate improvement opportunities in addressing patient experience issues (Vyas et al., 2022). However, the HCAHPS survey is not without its limitations, with critics such as Vyas et al. (2022) asserting the survey lacks in-depth

narratives and does not measure what really matters to patients. Additionally, Junewicz and Youngner (2015) assert that pressure to earn desirable ratings can lead to bad medicine, partly because of efforts to manipulate patient perceptions that will cause patients to rank hospitals and providers more favorably.

Furthermore, within hospitals much of the accountability to achieve desirable patient experience scores rests with nurse managers. Although the HCAHPS survey asks patients about many areas of communication (e.g., communication about medications, communication with doctors, etc.), the survey domain that addresses communication with nurses is the primary driver of performance on several other domains (Dempsey et al., 2014), including patients' overall ratings of the hospitals.

Nurse leaders play a vital role in influencing the patient experience. Maintaining a positive organizational culture is one key driver of patient experience (Niederhauser & Wolf, 2018). Toward this end, nurse managers essentially influence organizational culture by setting the tone on their own units for creating positive, communicative work environments where frontline nurses feel heard and valued (Garon, 2012; Hartung & Miller, 2013). When such support is lacking, decreased quality of life and burnout among staff nurses can occur (Kim & Lee, 2009). Hartung and Miller (2013) found that nurse leaders themselves believe that communication is the most important part of their jobs and that they in fact have a crucial impact on communication within their units, as well as overall staff well-being. They consider this vital to their success.

However, if nurse managers are highly stressed by immense job pressures—including expectations to deliver optimal patient experience scores that in turn drive reimbursements (Dempsey et al, 2014; Faller, 2015) —it may raise a question on whether

such pressures may inhibit their abilities to foster a positive communicative environment on their respective units.

Extant research cited within this dissertation's literature review explores nurse manager stressors, and some of that research highlights organizational expectations to deliver on patient experience measures. However, what is not known is the magnitude to which nurse managers are stressed by these expectations, whether they consider the expectations (and resulting initiatives to boost patient experience scores) to be unreasonable or not feasible, and whether these expectations create any semblance of role ambiguity or role conflict among them. Furthermore, if nurse managers do indeed experience significant stress related to delivering on HCAHPS and other patient experience measures, to what extent does it hamper their abilities to maintain open lines of communication with organizational leaders, as well as the staff nurses that report to them?

These are the questions that comprise the scope of this study. Because little research exists that examines these issues, this study will seek to gain deeper understanding and employ a qualitative approach consisting of semi-structured interviews with registered nurses who currently or recently managed inpatient hospital units either as nurse managers or assistant nurse managers.

## Theoretical Framework

The issues put forth are inspired from the lens of structurational divergence theory (Nicotera et al., 2015), a framework that has often been used to explore communication disconnects within the nursing realm. Structurational divergence theory (SDT) posits that when incompatible social structures (such as the hierarchal relationship between health

organization leaders and nurse managers, or nurse managers and frontline nurses) contribute to a situation, the clash creates unresolvable conflicts. These conflicts are exacerbated by simultaneous compulsions to "fulfill irreconcilably oppositional obligations, creating a downward spiral of communication that circles back to escalate the conflicts" (Nicotera et al., 2015, p. 372).

For instance, structurational divergence (SD) may apply with hospital leaders' intense focus on "making the score" to compare favorably with competitors and optimize reimbursement. This focus may conflict with nurse manager priorities to manage their patients' best interests. Likewise, nurse managers' efforts to "toe the line" as they communicate management directives to their staff nurses may conflict with efforts to ensure their staff nurses are satisfied with their jobs and not suffering from burnout.

These communication challenges do indeed present a conundrum for nurse managers who may feel "stuck in the middle." This research will seek to delve into nurse manager experiences of accountability for patient experience metrics and whether this accountability adversely impacts organizational communication dynamics that result in SD. Additionally this research explores how SD could ultimately be detrimental to nurse manager and staff morale, and in turn the patient experience.

# CHAPTER TWO: LITERATURE REVIEW

In this chapter, I first provide an overview of how patient experience is conceptualized and measured. I then present research that challenges the role of patient experience measures and whether they are associated with clinical outcomes. I then explain how accountability for patient experience measures on inpatient units often rests with nurse leaders such as nurse managers and how this adds to the many stressors that nurse managers experience. I then delve into how effective communication must exist to ensure an optimal patient experience and how nurse managers are a key component to facilitating effective communication in a way that will ensure healthy organizational cultures that promote staff nurse engagement—engagement that is crucial for bringing forth superior patient experiences. Finally, I explain how organizational expectations to meet goals for patient experience measures may spur structurational divergence (SD), where a cycle of conflicting priorities among upper management, nurse managers and staff nurses ultimately leads to a negative spiral of communication.

## Patient Experience Overview

Patient experience serves as a thread that is woven throughout the fabric of one's healthcare journey. As indicated previously in The Beryl Institute's formal definition of patient experience, patient experience highlights four core concepts: interactions (every encounter), culture, a cross-continuum view, and perceptions (Wolf, 2017a). Healthcare leaders, for more than a decade now, are attuned to the fact that a focus on the patient experience is integral to maintaining a vital healthcare organization. This focus has been driven largely by national policy shifts toward value (Wolf, 2017a) and pressures to bring about meaningful healthcare reform (Zakkar, 2019).

However, the consensus of patient experience leaders is that current patient experience measures are outdated and should be modernized to reflect new modes of care delivery and shifts in patient expectations (American Hospital Association, 2019). Toward this modernizing, a more holistic view of patient experience is in order (Wolf, 2017a). It goes beyond just developing a list of distinct initiatives or a stand-alone pillar within an organization's strategic plan. It entails a broader, more strategic outlook instead of a task-oriented "checking of boxes." In fact, an intense focus on specific initiatives could do more harm than good, bringing on what Wolf (2017a) deems tactic fatigue. And while short-term gains from such tactics may be realized, they may not be sustained. Segon et al. (2020) stress that an intense focus on scores brings on unintended consequences, asserting that this focus takes time away from other patient care activities that are essential to providing sound medical care. Wolf (2017a) also maintains that such a focus on specific initiatives could hamper the progress of other priorities. Thus, current approaches to patient experience have in many cases spawned inconsistency, accountability concerns, and unsustainable outcomes.

**Viewing Patient Experience Holistically**

Wolf (2017b) calls for a more integrated view of patient experience—one that considers quality, safety, service, cost, and population health and is driven by engagement by patients and families, as well as healthcare staff. In reframing the concept of patient experience, Wolf (2017a) recommends that organizations strive to work toward broader, overarching principles. These include accountable leadership, a strong culture, an adoption of a formal definition of patient experience, and a process for continuous patient and family engagement, as well as the engagement of other stakeholders, such as

staff. Wolf (2018) points out that staff and provider engagement is one of the most prevalent drivers of patient experience. Thus, every person within a healthcare organization drives the patient experience—not just clinical personnel. One might argue that information systems staff within a healthcare organization—staff who have limited to no patient contact—could easily drive the patient experience by keeping an organization's computers operational and working to prevent cyberattacks. After all, a system crash would make accessing patient records impossible.

This engagement of healthcare staff directly impacts clinical and operational outcomes (Wolf, 2017b). But engagement is only one dimension of the many different dimensions comprising patient experience (Lavela & Gallan, 2014), and failure to integrate multiple dimensions into the broader concept could impede efforts to determine whether patient experience is approached correctly (Sheard et al., 2019).

**Determinants of Patient Experience**

Zakkar (2019) determined that there are at least five determinants of patient experience: the patient's lived experience of illness; the patient's subjective influences (such as expectations and perceptions that are influenced by beliefs, culture and past experiences); quality of healthcare services, including fostering a foundation of trust between providers and patients/caregivers; responsiveness of the healthcare organization to the non-health needs of patients; and politics of healthcare and the perspectives of healthcare providers (such as dealing with power differentials among staff members or between providers and patients). Furthermore, Zakkar found from a review of extant literature that provider perspectives see patient experience as a manifestation of patient satisfaction and patient engagement. LaVela and Gallan (2014) define *patient satisfaction*

as the affective judgment by the patient of the attainment of certain patient goals due to encounters with the health system and *patient engagement* as patients' positions about their present interactions that lead do a commitment toward their own optimal health and well-being.

Wolf (2017a) echoes that patient experience is often misidentified with patient satisfaction (as the terms are often used interchangeably) and that patient experience encompasses more breadth, whereas satisfaction measures perceptions in points of time. Experience is "the lasting story consumers carry with them. It colors the lens through which they see an organization" (Wolf, 2017a, p. 7). Additionally, Zakkar (2019) asserts that when considering the patient experience, providers tend to overlook patients' illness narratives. This could be due to the healthcare workers' increasing workload. Coulter (2013) opines that this is not about health professionals not caring, because most who enter healthcare do so because they want to help people. However, the focus on protocols, tasks, and techniques hamper healthcare staff's abilities to respond to patients' personal and emotional needs.

Thus, patient experience encompasses many different components. Yet the phenomenon of patient experience is complex, and as such it is a difficult concept to conceptualize and measure (Lavela & Gallan, 2014). Despite this, healthcare as an industry has attempted to measure patient experience for years, and these efforts have garnered mixed reviews.

## Patient Experience Measures

Although patient experience necessitates in-depth understanding of the many components that influence perceptions, efforts to measure patient experience occur

primarily through quantitative means. As mentioned previously, the concept of patient experience was derived from U.S. efforts to reform healthcare by decreasing costs and increasing value. A precursor to health system reform as it applied to metrics was development of the "Triple Aim" by the Institute for Healthcare Improvement (IHI). The Triple Aim prioritizes care experience, improved population health and reduced healthcare costs (Berwick et al, 2008). It is also worth noting that since 2008 the "Triple Aim" has expanded to include two additional areas of emphases—workforce well-being and safety; and health equity (Mate, 2022).

With patient experience established as a priority, the Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS (pronounced H-caps) was developed in 2002 by the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ).

**HCAHPS**

HCAHPS is a national, standardized survey that measures patients' perceptions of their hospital care. Because it is a standardized survey and the results are publicly reported, it enables comparison of hospitals on patient experience topics. All hospitals in the United States that receive government reimbursements, such as Medicare, are mandated to participate as part of the federal government's value-based purchasing (VBP) initiative, which materialized as part of the Affordable Care Act (ACA) to improve quality of care. Public reporting of hospital VBP data began in 2012, and in 2015 CMS added HCAHPS star ratings to the hospital compare website where scores are publicly reported (CMS, 2023b).

The survey, which can be administered via phone, mail, or email, is distributed to a random sample of patients from 48 hours after discharge to 6 weeks after discharge. To be eligible for the survey, patients must be at least 18 years old at admission, stay at least one night in the hospital, have a non-psychiatric principal diagnosis, and be discharged alive (Isaac et al., 2010). The survey consists of 29 primary questions, with a focus on frequency of communication (e.g., communication with nurses and doctors, communication about medications, staff responsiveness, discharge instructions). It also requests that patients provide an overall rating of the hospital on a scale of 0-10—with 0 the lowest and 10 the highest—and with only 9s and 10s considered "top box" (Silvera & Clark, 2016). Hospitals typically use survey vendors (such as Press Ganey) but may also collect their own HCAHPS data if approved by CMS. Hospitals may limit the survey to just the HCAHPS questions or include extra questions, including open-ended questions for the purpose of collecting qualitative remarks, beyond the HCAHPS items.

**The Pressure to Score**

Beginning with discharges in 2012, HCAHPS has been among the measures used to calculate value-based incentive payments to hospitals. The measurement of patient experience accounts for 25% of value-based (versus volume-based) purchasing scores and incentive payments (HCAHPS fact sheet, 2022). Currently, hospitals that do not meet CMS benchmarks may be penalized up to 2% of Medicare reimbursements (CMS, 2023a). Performance is assessed with what is deemed a "top-box" score—that is, the percentage of survey questions in which respondents assign the highest possible value (Poole, 2019). Additionally, survey vendors issue percentile ranks to hospitals that indicate how they compare to other hospitals featured within the vendor's database

(Mayer et al, 2021). Hospitals that score below the 50th percentile among all the hospitals they are compared to may receive less reimbursement, whereas those that score above the 50th percentile have the potential to receive financial incentives (Segon et al, 2020). Thus, patients' perceptions of their care literally determine the extent to which hospitals are paid.

## Questioning the Role of Patient Experience Measures

On most items the HCAHPS survey measures frequency rather than quality; yet it has provided insight about how patients evaluate their care. For instance, Silvera and Clark (2016) found that a single latent factor, reflected in five HCAHPS measures, corresponds conceptually to patients' evaluations of care—based on interpersonal interactions with their providers. These five HCAHPS measures include communication of doctors, communication of nurses, responsiveness of staff, pain management, and communication about medicines. Silvera and Clark deduced that the aggregation of these measures comprises a singular aspect of the care experience, referred to as the interpersonal care experience (ICE).

Still, quantitatively speaking, although the HCAHPS survey may provide an adequate guideline for determining how patients evaluate their care and, in turn, patient experience improvement opportunities (Poole, 2019; Vyas et al., 2022), the reliance on a primarily quantitative measure such as the HCAHPS has garnered some concern and criticism.

### Making the Score—A Topic of Contention

Anhang Price et al. (2015) argue that providers should not be held accountable for patient experience measures because there are flaws with the HCAHPS measure.

Namely, the authors claim that consumers do not have the expertise needed to evaluate care quality; that patient "satisfaction" is too subjective to measure; that intense focus on improving patient experience may prompt healthcare providers to give patients what they want, even if the care is inappropriate or ineffective; and that some of the scores reported by HCAHPS are beyond providers' control. (For instance, something as simple as receiving a cold cup of coffee from nutrition services could impact the overall scores of the nursing unit.)

Research by Rosenau et al. (2012) complements this sentiment, asserting that zero-sum designs—where some organizations are rewarded at the expense of others—actually impede organizational performance and achievement. As a result, those at the low end may simply get discouraged and quit trying to earn optimal scores. Mayer et al. (2021) echo this, asserting that when percentile and ranking scores are used to determine reimbursement, it absolutely produces a system of winners and losers. In other words, no matter how well hospitals perform on their "top-box" scores, there will always be "losers." Such a scenario can be likened to a college student receiving a 97 on an organic chemistry exam, only to be informed it is a failing grade because all others in the class scored 98 through 100 on the exam.

Because the bar is set so high, a tiny dip in top-box scores can result in a significant shift in percentile rankings (Vyas et al., 2022). Bland et al. (2022) note that some CAHPS measures—such as questions about how well providers communicate—may very well be "topped out." They explain that a measure is "topped out" when a high percentage of patients answer questions about a high percentage of providers in the most positive way. Thus, the measures have little variance. This results in an extreme

clustering of high scores—where about two to three percentage points separate the majority 30th and 90th percentiles. Given this, Bland et al. suggest that analytic focus should shift to focus only on those providers scoring unusually low on the measures. Richman and Schulman (2022) illustrate the fragility of scores in relation to physicians:

> Imagine a clinician who treats 120 patients each month and enjoys a mean patient rating of 9.5, well above the national mean. With a survey response rate of 20%, it takes only 1 disgruntled patient giving a score of zero to cause the clinician's mean score to plummet below 9.1 (p. 2209).

Richman and Schulman (2022) add that the high-stakes use of patient experience measurement tools "renders them at best meaningless" (p. 2210) and at worst responsible for clinician burnout and bad medical care. W. Edwards Deming, a renowned 20th century performance management scholar, warned that merit ratings are designed only to boost short-term performance (to the detriment of conducting successful long-term planning), and they serve more to cast fear, demolish teamwork, and fuel rivalry (Deming, 2013).

Thus, scholars summarize that stiff competition to outdo competitors can adversely impact healthcare. The system of "grading on the curve" can be polarizing and detrimental, as the competition for hospitals to outrank each other creates disincentives for hospitals to share best practices with others, as doing so may be to the peril of their own rankings (Vyas et al., 2022).

**A Better Way to Measure**

The better way to measure patient experience, according to Mayer and associates (2021), is to use raw scores (ratings) instead of percentiles (rankings), with transparent reporting of results. They opine that a ratings-based system stirs intrinsic motivation

among health providers, as they are competing against themselves. Golda et al. (2018) add that intrinsic factors are "the real reason to care about the patient experience" (p. 649). Rosenau et al. (2012) agree that nonfinancial rewards such as praise and public recognition have been overlooked. They maintain that a standard of excellence should be established early on—one where all who meet the standard should be rewarded. This is superior to percentile scores and rankings that rely on extrinsic motivation and that are linked to incentive systems that, in turn, inhibit teamwork and the sharing of best practices (Rosenau et al., 2012).

Another perspective offered by Poole (2019) is that perceptions of patient experience are largely subjective (despite tools to quantify them) and that patients could assess their care based on a variety of components that may have nothing to do with the clinical care, such as scheduling, wayfinding, or dining. Segon et al. (2020) echo these concerns, noting that validity of the current patient experience measures is called into question due to the phenomenon of "negative anchoring"—that is, the notion that one negative encounter (out of possibly hundreds or thousands during one experience journey) could adversely impact responses to all questions in the survey. For instance, if patients are not satisfied with their experiences due to unrealistic expectations for pain control or about treatment plans for terminal illnesses, they may be more likely to respond negatively to all questions—including those about providers' communication practices. Junewicz and Youngner (2015) asserted that for data to be valid and useful, patients would need to step outside themselves, from the "sick role" into that of a more even-keeled consumer (which is not realistic, given the vulnerabilities of sick individuals). Manary et al. (2013) expressed concerns that patient feedback is not credible

because patients are not medically trained and that the feedback that they do offer is based on fulfillment of their immediate desires, such as receiving pain medications, regardless of benefit.

Lavela and Gallan (2014) claim that measurement is not inherently bad, as it does help health care organizations to pinpoint improvement opportunities, enhance strategic decision making, and establish benchmarks for care. However, they claim that relying mostly on quantitative methods does not reflect the full picture of patients' experiences. As such, they argue that a mixed methods approach that includes more qualitative data will provide a deeper understanding of the patient experience, particularly what matters most to patients (Gallan et al., 2022; Lavela & Gallan, 2014). In addition to incorporating more robust qualitative data collection measures within the HCAHPS, qualitative data from other sources—formal complaints, social media, and nurse manager rounds with patients—should be used to complement patient experience quantitative data. Other researchers (e.g., Graham &Woods, 2013; Sheard, 2018) agree, positing that there are many different dimensions to patient experience and that failure to juxtapose these dimensions could net meaningless measures.

**A Lack of Narrative Data**

Other researchers have also noted that the consideration of qualitative data is important, particularly the richness of narrative, even though some might view it as inferior to more concrete quantitative data (Greenhalgh et al., 2015):

> …many people…acknowledge that qualitative research to describe the patient experience, including the perspective of carers and significant others, can add granularity and meaning to research findings consisting of effect sizes, confidence intervals and grand means. Nevertheless, they also tend to retain a hierarchical view of the value of such research, viewing qualitative evidence as less robust than quantitative

> evidence, rather than complementary to it and addressing different questions (p. 5).

Greenhalgh et al. (2015) contend that subjective evidence, or what the patient feels, is just as important as objective evidence. Vyas et al. (2022) and Zakkar (2019) agree, asserting that systems of measurement need better means to capture the patient voice—that is, spending less time checking boxes for ratings and more time analyzing narratives to seek out what really matters to patients. This is not always possible with surveys that in themselves have limitations (Vyas et al., 2022). For instance, frequent patients who have multiple hospital stays may be asked to complete the same survey time after time. As a result, survey fatigue could set in and thus, patients may provide the same answers to questions repeatedly. Additionally, the surveys are too lengthy, which can also contribute to survey fatigue.

**Confusion about How to Use Survey Results**

Furthermore, when the quantitative results come in, confusion occurs about how to use the results to drive improvement. In a qualitative study exploring hospitalists' perceptions of patient experience measures, hospitalists expressed that patient experience metrics were useless for providing essential feedback that would help them improve their clinical skills (Calcaterra et al., 2017). According to Vyas et al. (2022), surveys merely measure episodes of care and miss the wider journey that includes experiences between episodes. Also, the time lag between when patients are surveyed and when organizations receive the results (often up to 3 months) means the data is outdated before it is even received. Agarwal et al. (2021) calls for systems that net more timely data, such as the adaption of digital data systems.

Currently, these results lack actionable information that provides specific guidance on how to improve (Segon et al., 2020). Vyas and associates (2022) add that the focus on patient measurement has become less about what actions to take to improve and more about the scores in of themselves. According to Oben and Corliss (2021), "there are unintended consequences of this close association between HCAHPS and the patient experience. The difference between the two is often blurred, unappreciated, misunderstood, or ignored—to the detriment of both" (p. 1).

In an analysis of patient experience measures, Golda et al. (2017)—all of whom are physicians—stressed that the intent of measuring patient voices is to learn and improve to a degree that clinical care is excellent and patient experience is optimal:

> The measures are not the goal; they are always in service to and a quantitative proof of an organizational mission to provide high-quality care. When scores are projected and communicated as the goal, physicians and delivery systems are at risk for behaviors that they believe will hit a score, thereby opening the door to pressures for providing inappropriate care at the patient's request (p. 647).

These issues raise the question of whether patient experience measures—measures that make up a significant component of value-based-purchasing programs—really do drive clinical improvements. Rather, Junewicz and Youngner (2015) found that hospitals that are motivated by finances often will manipulate patient responses to patient experience surveys through the use of creative scripting that they expect nurse and other clinicians to employ. In other words, they essentially "teach to the test."

### The Relationship Between Patient Experience Measures and Clinical Outcomes

More than a decade ago, Isaac et al. (2010) did find a consistent relationship between patient experience perceptions and clinical performance. Furthermore, Owens and associates (2017) found statistically significant associations between higher CMS star

ratings and lower rates of in-hospital complications and readmissions. Golda et al. (2017) noted that patient experience scores have been correlated with higher clinical quality, indicating that measuring patient experience has brought to light quality issues related to communication. With that said, these authors caution that when using patient experience metrics as a proxy for healthcare quality, reservations do exist. To illustrate this point, one study they cite is that of Fenton et al. (2012), whose research shows that although higher patient experience scores were related to lower emergency department utilization, they were also associated with higher rates of inpatient stays, higher healthcare and prescription drugs costs, and mortality. Research by Hachem et al. (2014) yields paradoxical findings, revealing higher HCAHPS scores on questions regarding nurse listening and doctor explanations were linked to decreased risk of readmission, yet higher HCAHPS scores regarding communication about discharge information were linked to an increased risk for readmission.

**Research Shows Mixed Results**

Research, at best, shows mixed results pertaining to the relationships between patient experience measures and clinical outcomes. A data assessment comparing clinical outcomes with HCAHPS data by Papanicolas et al. (2017) concludes that there is no evidence that suggests government value-based programs (of which patient experience is a component) have a beneficial effect and that the bulk of the improvement that has happened took place prior to implementation of value-based programs. A systematic review conducted by Nararro et al. (2021) indicates the possibility that patient experience ratings are minimally associated with clinical and quality outcomes, yet results are inconsistent, and it is unclear whether patient experience is a direct driver of outcomes, as

other factors may influence those outcomes. Dottino et al. (2019) also found limited results in correlations between patient experience and outcomes related to various indicators such as morbidity, mortality, and readmissions. Ryan et al. (2015) performed a data analysis that reveals value-based purchasing programs, of which HCAHPS is a component, did not yield improvement for either clinical processes or patient experience. Junewicz and Youngner (2015) also found no clear connection between published patient satisfaction data and healthcare quality.

Sacks et al. (2015) contend that when it comes to the relationship between patient experience scores and clinical outcomes, the incentivization of one measure could be to the detriment of the other. In fact, Stanowski et al. (2015) observed that hospitals that spend more money have higher levels of patient experience, though they notes that putting more dollars toward certain efforts could defeat the purpose of pay-for-performance in the first place, stating that "if incentives exist to reward outcomes related to higher costs, the pay-for-performance program could sabotage the goal of lowering the cost of care while increasing quality" (Stanowski et al., 2015, p. 280).

Junewicz and Youngner (2015) caution that pressure to earn good ratings can lead to inappropriate care, as clinicians will be more likely to tell patients what they want to hear, rather than what they need to hear. Research by Weeks et al. (2012) mirrors this assertion. In their study, they found that cancer patients harboring less than realistic beliefs that they would be cured rated their providers more favorably (thus, patients perceived their providers more negatively when those providers delivered bad news). As such, to earn favorable scores clinicians are tempted to withhold information or perhaps put a false spin on it.

Dottino and associates (2019) also warned that incorporating HCAHPS scores within a pay-for-performance incentive program could yield negative consequences. Their study did not show a positive association between HCAHPS and clinical outcomes. Yet they suggested that it is reasonable to conclude certain aspects of the HCAHPS survey, such as communication, could *overlap* with quality care.

Communication was a factor in a study performed by Dy et al. (2016), who found that higher patient perspectives of care pertaining to physician communication were minimally associated (yet not significantly so) with lower readmissions among cardiac patients, although this same association was not found to impact 30-day mortality. Results from Odom-Maryon et al. (2019) echo the link to communication, finding that hospital-acquired pressure ulcers among Medicare patients occurred less frequently when their perceptions of nurse communication (as indicated on HCAHPS) were higher. Yang et al. (2018) compared HCAHPS scores with quality indicators among more than 4,500 hospitals and found a positive, yet small effect size between staff responsiveness and 30-day readmission rates, although the association between readmission rates and communication with either physicians or nurses was not confirmed. Research by Velez et al (2017) found no correlation between HCAHPS scores and communication. The systematic review by Navarro et al. (2021) explored the growing interest in learning more about how patient experience relates to outcomes. It included several studies that examined the relationships between patient-provider communication and outcomes where some significant associations, driven primarily through provider empathy and respect, were found.

All in all, although some studies demonstrated miniscule positive associations between patient experience measures and clinical outcomes, most of the research cited did not yield significant results. This calls into question whether zero-sum designs (characterized by the current VBP system) that divide hospitals into teams of winners and losers are effective. Moreover, such structures provide food for thought on whether they truly make a difference or whether they cause more harm than good by generating increased stress and anxiety among those who are accountable for HCAHPS scores. HCAHPS scores as assessed by patients, after all, are significantly more subjective than cut-and-dry clinical quality indicators, such as rates of readmission or hospital-acquired infections. Within hospitals, this accountability for the HCAHPS scores routinely falls upon the nurse managers who are at the helm within their inpatient units.

## Nurse Manager Challenges

Little research, if any, has examined how the zero-sum nature of HCAHPS, one that creates systems of winners and losers, may exacerbate stress that nurse leaders already experience. What is known from research is that nurse leaders do experience multiple stressors. Results of a longitudinal study recently published by the American Organization for Nursing Leadership (AONL, 2021) outline nurse managers' current primary challenges. Managing staffing shortages tops the list, followed by efforts to deal with low staff morale and burnout. And with respect to themselves, the emotional health of nurse leaders is plummeting at an alarming rate. The rate of decline is so high that nurse managers, more and more, desire to leave their professions. COVID-19 has aggravated this situation. Middleton and associates (2021) found that since the start of

COVID-19 approximately three-quarters of nurse managers report high anxiety, with more than 40% revealing they have considered leaving their jobs.

**New Nurse Managers Must Sink or Swim**

Such anxiety experienced by nurse managers could be indicative of lack of training from the start to become nurse managers. Weaver Moore et al. (2016) analyzed data from a larger data set that explored how nurse managers contribute to healthy work environments. They found that nurse managers feel they are thrown into the position and "learning on the fly," making for a somewhat traumatic and haphazard approach for adapting into their positions. Focus groups conducted by Miltner et al. (2015) suggests that few nurse managers receive any formal orientation to their roles, which in turn adversely impacts role performance. They found that nurse managers were frustrated at the reactive nature of their jobs, spending most of their time on day-to-day functions (e.g., scheduling, payroll, tending to organizational mandates). As such, little time exists for proactive planning. Nurse managers suggested that their jobs were more about figuratively "holding the fort down" in the monitoring of tasks rather than actually leading a team.

**Indicators of Structurational Divergence**

Beyond the previously mentioned stressors, nurse managers feel a lack of role clarity, or that expectations of their jobs are not clear or realistic (Miltner et al., 2015). Moreover, nurse managers often find themselves experiencing role conflict—or competing demands (Kath et al., 2013). These conflicts pit the organizational performance expectations of the "higher ups" against those of frontline staff nurses (Miyata et al., 2015), who feel management expectations are unreasonable. As a result,

Miltner et al. (2015) found that nurse managers often find themselves stuck in the middle, without any kind of a voice at the organizational level. Dunham-Taylor (2013) also found that nurse managers are often caught in the middle. This presents a conundrum of sorts, as nurse managers are expected to have good relationships up, down, and across the organization simultaneously, which is not always realistic.

But when caught in the middle, they often endure a disconnect between management and the frontline nurses responsible for providing quality care to patients. This can produce moral distress—when persons believe they know the right things to do but feel powerless to do them due to organizational and other constraints (Jameton, 1993). Nurse managers have reported high levels of moral distress due to the struggle to balance administrative and patient care responsibilities (McAndrew et al., 2018).

Nevertheless, despite this feeling of lack of control, nurse managers are core players who drive hospital operations, particularly in this day where hospital reimbursement is tied to pay-for-performance mandates to not only produce optimal clinical outcomes but also meet patient experience goals. Toward this end, hospital organizations strive to increase their HCAHPS scores through a variety of initiatives representing patient experience best practices.

**Patient Experience Initiatives**

Patient experience initiatives include those such as hourly rounding (Gliner et al., 2022), bedside shift reporting (Dorvil, 2018; Miller et al., 2018; Radtke, 2013), and implementation of the AIDET communication framework (Huron Consulting Group, 2022) or the C.O.N.N.E.C.T. (Barden & Giammarinaro, 2018) communication

framework (see Appendix D for more information on these frameworks). Both of these frameworks are designed to facilitate consistent communication with patients.

Although these initiatives in of themselves have been shown to be essential for boosting patient-provider communication and enhancing the patient experience (Gliner et al., 2022), their implementation adds to the administrative duties of nurse managers who are accountable for both implementation of and staff compliance with the practices. Morton et al. (2014) caution that a multitude of improvement initiatives should not take place concurrently, stressing that because nurse leaders must pay attention to so many priorities at a time, implementation success of improvement initiatives is more likely when there are not too many efforts implemented simultaneously. Not only that, frontline staff nurses can be quick to criticize improvement initiatives, arguing that vast workloads make hourly rounding on patients difficult (Shepard, 2013; Toole et al., 2016) or that bedside shift reporting inhibits communication between nurses who may need to discuss sensitive patient issues (Cairns et al., 2013; Cipra, 2016; DeCelie, 2020; Small & Fitzpatrick, 2017). However, research by Fung et al. (2008) is worth noting, as they found that while the publication of patient experience data prompts hospitals to launch an array of initiatives, these initiatives do not always yield quality improvements.

Nurse managers themselves are expected to allot significant time toward conducting purposeful rounding on patients, much of which is less about conducting meaningful conversations with a select few patients than it is "checking boxes" with a large percentage of patients on their units (Clancy, 2018). Ideally, this rounding on patients enables nurse managers to build relationships and trust, as well as gather feedback (Winter & Tjiong, 2015) that, in turn, will boost HCAHPS scores (Morton et

al., 2014; Tothy et al., 2018). But tests of correlations between nurse leader rounding and patient experience have yielded mixed results. Littleton et al. (2019) did find that increased quantity of nurse leader rounding resulted in a statistically significant improvement in patient satisfaction with care transitions, as measured with a care transition tool (not HCAHPS). However, Winter and Tjiong (2015) found that there was no correlation between how patients responded to specific HCAHPS questions and how they responded to questions posed by the nurse leaders who rounded on them. Additionally, Gliner et al. (2022) found that nurse leader visits did not play a significant role in reducing fall risks, independent of communication and frontline staff nurses' rounding frequency. With these mixed results, the effectiveness of nurse manager rounding on patients (in terms of boosting HCAHPS scores) is uncertain.

Dunham-Taylor (2013) opines that the pressure to achieve performance goals for maximizing HCAHPS represents just one of many stressors for nurse managers. Given that the U.S. healthcare system is struggling to recruit and retain people to fill these vital roles, it stands to reason that hospital leaders should aim to minimize stressors experienced by nurse managers. This brings to light a question that has yet to be conclusively answered within the body of research, and one that is posed as the first question for this study:

*RQ1: What are nurse manager perceptions of patient experience scores in relation to stress?*

## Communication as Essential to Patient Experience

Although it is unclear whether patient experience communication scores are associated with positive health outcomes, research does show that communication is

nonetheless important to patients, and the HCAHPS survey does, for its part, attempt to measure communication. Of the questions posed to discharged patients on the HCAHPS survey, a sizable majority of them focus on frequency of communication. For instance, the communication with nurses category is assessed by asking patients frequency on three items, with the top box value being the response of "always":

- During this hospital stay, how often did nurses treat you with courtesy and respect?
- During this hospital stay, how often did nurses listen carefully to you?
- During this hospital stay, how often did nurses explain things in a way you could understand?

Other questions focus on other aspects of communication—such as communication with doctors and communication about medications. It stands to reason that the largest chunk of the HCAHPS would cover communication issues, as a multitude of research has demonstrated a clear positive association between quality of communication and patient experience (Chan et al., 2018; Dietz et al., 2022; Halm, 2020; Jenson et al., 2020; Klint et al., 2019; Nørgaard et al., 2012; Royal & Kedrowicz, 2017; Timmermann et al., 2015).

**Patient Experience: Going Beyond the Clinical**

Research finds that effective communication does not just entail dialogue about clinical issues. Rather, patients desire their communication with their providers to go beyond talk of their medical conditions, as they value empathy, compassion, and humanization by their care providers (Tolotti et al., 2022; Vyas et al., 2022; Wolf, 2018; Zakkar, 2019; Zimmerman et al., 2020). In other words, they desire to be treated as people, rather than merely "patients." Although this sounds simple, it is not always easy for care providers to render. And this era of COVID-19 exacerbates the challenges that

providers experience to provide personalized care, making hospital settings even more dehumanizing for patients as healthcare professionals experience more stress (Middleton et al., 2021). This is due to a "fight or flight" mentality—a mentality experienced by healthcare professionals whose need for self-preservation has eroded their interpersonal skills (Jhawar et al., 2021).

Unfortunately, this erosion of skills is detrimental to patients. Denniston et al. (2018) analyzed written narratives about patients' communication experiences with their healthcare professionals and found an overarching theme across the data indicating that patients want to feel valued. "Being valued," for the purposes of this study, was characterized by patients feeling they were listened to and acknowledged and that their providers spent sufficient time with them. Denniston and associates (2018) further found that when patients feel they are valued, they are more likely to be engaged in their care and compliant with the treatment plan. Mikesell and Bontempo (2022) also found that the establishment of trust was integral to patients' care experiences. Indeed, when providers establish a foundation of trust with their patients and show patients that they care, it positively impacts patients' perceptions of their experience. Lidgett (2016) found that this can be accomplished simply by sitting down for a few minutes to chat with patients, and in turn connect with them. Lidgett asserts that focusing on those connections will optimize the patient experience. Lidgett also suggests that nurse leaders would do well to ask nurses about their patients, particularly things about them that have nothing to do with why they are in the hospital. Those who can share such details are more likely to connect with their patients.

**No Time to Connect**

Connecting, however, can be challenging for nurses. In research conducted with ICU nurses by Yoo et al. (2020), the participants experienced more difficulties communicating with patients and their families than with the performance of their clinical duties:

> Although nurses intend to treat patients and their families with empathy, they frequently lead one-way conversations when pressed for time in the ICU. In addition, their usual way of talking, such as their dialect and intonation, can sometimes be misunderstood and cause offense. Participants experienced difficulties communicating their sincerity to patients and their families. (p. 5)

Yoo et al. (2020) also found that that while nurses realized the importance of verbal communication and physical contact in providing care, application of this was not easy in clinical practice, particularly in high-stress situations when patients are in a critical state. Participants expressed that because they are often pressed for time, they will limit conversations with patients to the point where they seem blunt or unfriendly. Although the nurses' intentions were to communicate as compassionately and sincerely with patients as possible, the research found that participants were more focused on tasks associated with patient care, rather than on communication. Despite these challenges, nurses did at least recognize that communication—particularly expressions of empathy and respect, as well as active listening—is vital for providing quality care.

Trotta et al. (2020) contend that other factors play into how patients perceive their communication with nurses, including their engagement with patients, anticipation of patient needs, and their responsiveness to their concerns. These factors go beyond what HCAHPS measures:

> Our findings do not endorse the HCAHPS approach to measuring patient satisfaction with nurse communication nor suggest that it provides a complete picture of the experience of nurse communication or high-quality nursing care more generally. There are other aspects of nursing care that patients value, which arguably deserve greater weight in benchmarking or value-based purchasing (p. 576).

Research findings by both Gliner et al. (2022) and Trotta et al. (2020) suggest that healthcare organizations should focus more on nurse communication behaviors. This is accomplished in part by developing positive organizational cultures and good work environments that enable nurses to better apply these behaviors. Niederhauser and Wolf (2018) concur that strategic positioning of patient experience as a focal point of an organization necessitates the existence of a strong, positive organizational culture. And nurse leaders, they contend, play an important role in honing such a culture and, in turn, improving the patient experience.

## The Relevance of Nurse Manager Communication

Nurse managers are crucial for ensuring staff nurse satisfaction and optimal patient outcomes (Ulrich et al., 2019). To facilitate seamless organizational processes, ensure quality of care, and promote healthy work environments, nurse managers must be effective communicators (Adriaenssens et al., 2017; Colomer-Sanchez et al., 2021). Nurse managers who are skilled communicators are essential for ensuring that quality care is provided (Joslin & Joslin, 2020). Manning (2017) found that communication is "the hallmark of transformational leadership style" (p. 442) and that when nurse managers possess this leadership style, it results in a greater likelihood that staff nurses will engage with their jobs, which in turn promotes organizational success.

Owens et al. (2017) found that, by and large, a healthcare organization's success relies on the quality of its organizational culture. They define culture as a system of

learned behaviors and ideas that result in shared philosophies, values and beliefs that, in turn, bond organizational members together. The Institute of Medicine (IOM) calls for workplace cultures where communication flows smoothly, in a way that transcends hierarchical structures (Donaldson et al., 2000). Stress, however, can impede the climate of an organization, primarily through the stifling of communication skills (Van Bogaert et al., 2015). Nurse managers, for their part, greatly influence the culture of the work environment (Ulrich et al., 2019).

**Culture Beats Strategy**

Owens et al. (2017) recommend that organizational leaders keep culture in mind if they want to retain staff, particularly in their focus of instilling employee pride and making staff feel proud that they are part of the organization. Nurse managers influence nurse work engagement (Kunie et al., 2017) and nurse retention (Roche et al., 2015). Feather et al. (2015) found that staff nurses strongly value effective nurse manager communication. Specifically, they appreciated managers who communicated consistently with them and were willing to listen to their own personal and professional needs, and they expressed that when this happens, it enhances trust between staff nurses and nurse managers. They further found that when staff felt excluded and unaware of decisions being made within the organization, effective nurse manager communication was lacking.

Although research has shown that nurse managers are, collectively, competent communicators even under stress (Colomer-Sanchez et al., 2021), in their roles they often experience communication challenges. In particular, Marx (2014) found that nurse managers cite structural barriers as impediments to communication. For instance, because they juggle so much work, they are often overwhelmed with the vast amount of

information that needs to be communicated and are unable to spend an adequate amount of face-to-face time with their staff nurses. Also at play could be a concept that West (2000) deemed "structural secrecy," where information is not shared among organizational members simply because they are situated at different levels within a hierarchy.

**Administrative Priorities versus Patient Priorities**

Udod et al. (2017) echo the sentiment that organizational practices and structures impede communication and that nurse manager work demands are driven more by administrative priorities than by nursing or patient-related priorities. In particular, communication breakdowns occur primarily because of nurse manager work overload, shifting organizational priorities, and unrealistic organizational expectations. For instance, Udod et al. add that often senior management level decisions to implement change are done so without the resources needed to achieve the goals.

For their part, nurse managers must manage demands from sources both above and below them, and when the demands conflict with each other, they produce an immense source of stress (Kath et al., 2013; Miyata et al., 2015) and threaten nurse manager autonomy (Penconek et al., 2021). Furthermore, Kath et al. (2013) assert that when nurse managers continue in such conditions, their thoughts are usually consumed with their workloads, thus causing a "negative spiral" (a component of SD) that can ultimately lead to burnout or nurse managers leaving their jobs altogether.

**Nurse Managers Set the Tone**

The cited research indicates that inpatient nurse managers are indeed the "glue" that holds their respective hospital units together, and the key ingredient in this "glue" is

communication. Regarding organizational goals to achieve established patient experience measures (particularly HCAHPS) raises the question about how and when nurse managers broach this topic with their staff nurses and whether staff nurses are receptive to how these expectations are presented to them. Additionally, another point of inquiry would be how nurse managers perceive their staff's attitudes about working toward patient experience goals (such as through carrying out a host of initiatives to boost HCAHPS scores) and whether those attitudes enhance teamwork to provide high quality care or (to the opposite) adversely impact teamwork and morale. As such, the following research question is proposed:

*RQ2: What is the relationship between patient experience goals and communication?*

Ideally, when staff work together to bring about optimal patient experiences, it leads to greater satisfaction by all parties—not just patients but also nurses and physicians (Wolf, 2018). However, if the goals center around achieving just the numbers themselves (such as HCAHPS top-box scores and percentile rankings), could there be conflicting priorities between those at the top who are focused on boosting the scores and those on the front lines of care who feel they are overwhelmed by too many improvement initiatives handed down from the top? And how do nurse managers, often stuck in the middle, mediate communication processes to alleviate conflicting goals? With the assumption that breakdowns in communication do occur throughout the levels of hierarchy and that sometimes these breakdowns are not solvable, this study is inspired by the theoretical framework specific to structurational divergence theory (Nicotera et al., 2010).

## Structurational Divergence Theory

Structurational divergence theory (SDT) is an extension of structuration theory, which posits that the individuals' social interactions facilitate societal, institutional, and organizational meaning-making (Giddens, 1984). Applications of structuration theory assume that contradictions in meaning that result in conflict can be managed. However, SDT considers instances where these contradictions are unresolved, resulting in a perpetual cycle of conflict. Thus, communication is stalled. It is important to note that the foundations of SD are within an organization, not individuals. Thus, SD is "an organizational problem manifesting in interpersonal communication" (Nicotera & Mahon, 2013, p. 110). The SD cycle is rooted in cultural and institutional restraints (Nicotera et al., 2014). These institutional factors can result in poor communication and conflict cycles (Nicotera et al., 2015).

### The SD Cycle and the SD Nexus

Nicotera et al. (2010) proposed two cycles of structurational divergence—the SD-nexus and the SD-cycle (see Figure 1). The SD-nexus posits that the varying hierarchical positions that individuals hold within organizations can cause contradicting meaning structures. Thus, SD-nexuses occur as the result of institutional positioning (where the parties are on opposite sides), and in turn that causes constant and repeating cycles of conflict. For instance, nurse managers may experience repeating cycles of conflict and feel "stuck in the middle" as they attempt to toe the line with management in efforts to bring forth optimal patient experience scores (and, in turn, maximize reimbursement). However, at the same time they may experience pushback from their staff, who feel the

increase in workload to implement various patient experience initiatives actually impedes their abilities to provide comprehensive care to their patients.

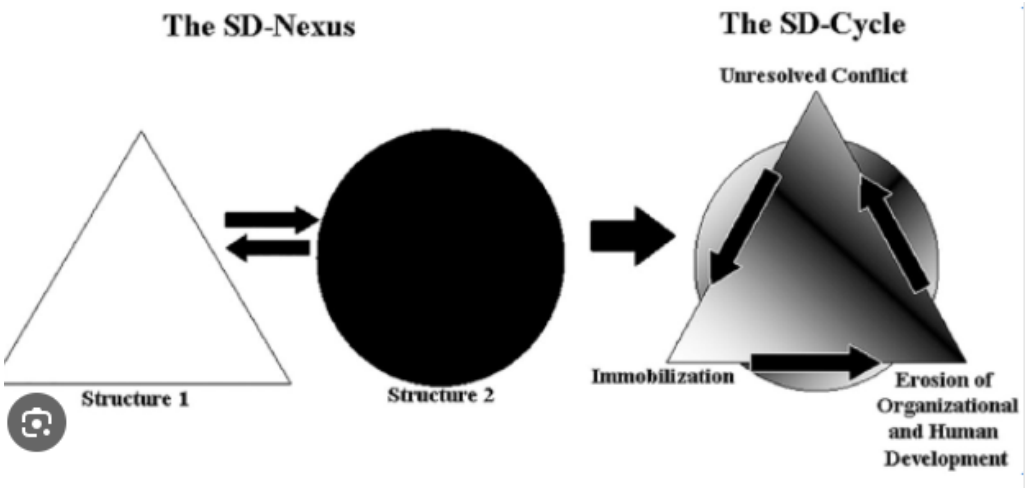


Figure 1: Structurational Divergence Theory

The SD cycle is characterized by the "negative spiral of communication" that results from the SD-nexus, thereby leaving the opposing parties stalled in any progress to move forward. For instance, if management priorities are to preserve a healthy bottom line that cannot be achieved without maximum reimbursements, they may issue directives down the line without any consideration of how such directives could impact front-line nurses. As such, nurse managers may attempt to explain staff concerns to management but feel that doing so may fall on deaf ears. As such, nurse managers may feel stuck in place, engaging in serial conflict about the same problems, with no end in sight.

Nicotera and Mahon (2013) assert that the incompatibility of meaning structures is not always clear, thus making it that much more difficult to pinpoint sources of conflict. Thus, without knowing the root cause of the conflict, it is difficult to formulate effective resolutions, and the parties feel they cannot change this state of limbo. Nicotera (2019) summarizes it this way:

> Those entrenched cannot make sense of interaction, cannot coherently use resources, and cannot apply rules smoothly. Because simultaneous oppositional structures are equally forceful and because the re-production of one violates another, the interaction system at the nexus is incoherent (p. 57).

**SDT and the Nursing Workplace**

SDT was developed to explore healthcare communication, specifically nursing communication. Nicotera et al. (2015) found that SDT provides an effective means by which to more fully understand, from a communication theory perspective, complex issues within the nursing workplace. The nursing profession has been particularly targeted for study. This is because nurses and nurse managers are institutionally positioned in ways that are conducive to the existence of incompatible meaning structures. Nicotera and Clinkscales (2010) explained that nurses juggle multiple roles, where organizational culture, professional and personal ethics, institutional policies, technical rules, and community culture (to name a few) are at play simultaneously.

One of the findings by Nicotera et al. (2015) was that role conflict is associated with SD. When role conflict among nurses exists, they experience a loss of agency (Nicotera & Mahon, 2013) and cannot perform well. As such, it impedes their abilities to meet others' needs. Nicotera et al. (2015), along with Nicotera and Mahon (2013), further found that poor conflict communication is positively associated with SD, yet good conflict communication is not related to SD.

Consequently, the loss of agency inhibits individuals' abilities to choose actions that transform structures. When such transformative agency is compromised, it can create role conflict that metaphorically places nurses "between a rock and a hard place" (Nicotera & Mahon, 2013). Unfortunately, many nurses tend to avoid conflict (Mahon &

Nictoera, 2011), and this, coupled with the tendency to take conflict personally, exacerbates the degree of SD (Malterud & Nicotera, 2020). This worsening of SD can leave nurses perplexed about the appropriate courses of action. Thus, SD also causes a lack of self-efficacy (the conceptualization of agency) that hinders nurse productivity (Nicotera et al., 2014; Nicotera & Mahon, 2013). Findings by Nicotera and Clinkscales (2010) indicates that such immobilization occurs due to unresolved conflicts between management and nurses.

Malterud and Nicotera (2020) delved deeper into the structure of SDT and suggested that perhaps a way to prevent, or at least minimize, SD is to manage escalation of the SD-nexus before it develops into an SD-cycle. However, minimal research exists to precisely determine where the SD-nexus transitions into SD-cycle within the conflict process.

### Structurational Divergence and Nurse Managers

Research related to SDT has concentrated largely on the nursing profession. However, a dearth of research exists that examines how SD exclusively impacts nurse managers. Given their susceptibility to experience role conflict and positions where they figuratively feel "stuck in the middle," they are constantly reconciling the demands of management at the top and the desires of the staff nurses they manage. As has been demonstrated via this literature review, structural conflicts pit management priorities to "chase the scores" against staff priorities to "just care for the patients" without being overwhelmed with increasing workloads centered around patient experience initiatives that are designed purely to boost patient experience scores. As such, nurse managers find themselves questioning what their true roles and priorities are, in a position to where they

are “damned if they do, damned if they don’t.” The exhaustion from this conundrum can create burnout and a motivation to leave. The statistics prior to the COVID-19 epidemic already indicated a significant void in nursing leadership in the future, and the pandemic has clearly made this worse (Middleton et al., 2021). Hence, this study proposes a final research question:

*RQ3: What are nurse manager perceptions about the relationship between conflict and patient experience goals?*

By examining this topic with an SDT lens, this study will be the first to explore and seek deeper understanding of nurse managers’ perceptions of patient experience measures and how these measures drive communication behaviors.

# CHAPTER THREE: METHODS

In this chapter, I begin by providing a self-reflexive consideration about why I conducted this research. Then I provide a rich description about the methods used to explore the topic. First, I describe my recruitment and sample of participants. Then I detail the protocol for data collection via an interest questionnaire and narrative interview. Finally, I describe how I analyzed the data and subsequently made conclusions about the data.

## Self-Reflexive Considerations

My mother was a registered nurse from the early 1960s until the late 1980s, and then she spent the remainder of her career teaching health professions at the high school level. She spent most of her nursing career in leadership roles. Her experiences sparked my own interest in nursing issues. In fact, at one point in my young life, I wanted to pursue nursing as a career, but for various reasons I chose to specialize in communication instead.

Although my general interest in nursing issues originated as a youth, my interest in patient experience measures and how they might lend to SD came about as a result of my own observations as a health communicator specializing in patient experience issues. In 2014 I was hired at a large hospital system to coordinate communications for the patient experience department. I quickly learned the importance that was placed on largely quantitative measures such as the HCAHPS. Part of my role entailed that I attend meetings, comprised of senior nursing leaders and frontline nurse managers, to review patient experience scores.

At these meetings, each unit's most current patient experience metrics would be reviewed, and if certain areas fell below a certain percentile rank, nurse managers (and in some cases, assistant nurse managers) were put on the spot and asked to explain why their units had not scored higher. My own impression was that nurse managers dreaded these meetings. At times, the tension in the room was evident, as exasperated senior managers tried to ascertain the reasons behind low scores and nurse managers were on the defensive, desperately trying to offer quick solutions that would help to boost the scores.

During this time (which, notably, was pre-pandemic), I also noticed a disturbing trend within the organization—frequent turnover of inpatient unit nurse managers. I was aware of the usual stressors that affect nurse managers—namely staffing challenges. I was also aware of frustrations where administrative duties impeded their abilities to spend the time they needed with their staff and with their patients. However, I could not help but wonder whether the pressure to defend and justify patient experience scores was the figurative straw that broke the camel's back. To further explore and contemplate this topic in preparation for my dissertation, I met virtually with a former inpatient unit nurse manager to assess whether pressure to achieve patient experience goals was an undue stressor for nurse managers. This person confided to me "off the record" that yes, it was indeed a huge stressor.

Although research has demonstrated there are not enough nurses in the United States, the pool of nurse managers is also dwindling, and up-and-coming nurses who feel unprepared to take the helm do not want to be thrown into choppy waters only to drown. Ultimately, my concern is that if hospitals do not maintain competent nurse managers to

lead inpatient units, it will have an adverse effect on the quality of patient care, as well as the perceptions that patients have about their care.

My position as a non-nurse reveals both strengths and weaknesses in my role as a researcher. A strength is that I am a true advocate for nurses. I have a genuine respect for them, particularly those working in the trenches, and have at least seen and heard enough to detect that the topic of patient experience measurement is contentious. However, I concede that my position contributes to my own empathic feelings about the challenges that nurse managers face. As such, I attempted to provide a balanced assessment of the data that includes a range of perspectives. Additionally, I worried that my position as a non-nurse hampered my own credibility with nurses considering participation in the study (as I am not "one of them").

Considering this, my hope was to garner trust and confidence among the nurse managers that I interviewed and do justice to this topic. I alone cannot change how patient experience metrics are structured in this country. My hope, though, is that this research provides a small glimpse into some of the lesser-known stressors that nurse managers face, as well as the resulting communication breakdowns that occur because of them. My goal is to start a dialogue—one that will ultimately help to address the organizational gridlock that occurs from this issue and help to move forward in a way that is advantageous not only for nurse managers and the organizations they serve but ultimately the patients and families that are served by them.

## Recruitment and Sample

The purposive sample consisted of registered nurses who have or have recently held management responsibilities in an inpatient hospital unit and have experienced

accountability for patient experience measures. Eligible participants were registered nurses who have served as either a nurse manager or assistant nurse manager on an inpatient hospital unit (such as medical/surgical, transitional care, or intensive care units) in the United States within the past five years. Assistant nurse managers qualified because they are integral to the functions of their units (Duggar, 2017; Regan & Rodriguez, 2011). Assistant nurse managers assume accountability for patient experience scores and are essentially in charge during night and weekend shifts when nurse managers are less likely to be on their units. Thus, they are responsible for implementing initiatives designed to boost patient experience scores.

Upon approval of the dissertation proposal by my committee, as well as approval from the University of Kentucky's Institutional Review Board (IRB approval 83718), I proceeded to recruit participants online via purposive sampling using several gateways to access. Although come may contend a limitation of the study to not draw my sample from just one organization (particularly because it is inspired by an organizational communication theory), I chose an online manner of recruitment to engage an adequate number of participants, as it would have been difficult to recruit a sufficient number via a single hospital or healthcare system. A further purpose of recruiting nurse managers from throughout the United States was to potentially facilitate understanding of their perspectives from across various hospitals and healthcare systems, as well as within various types of units (e.g., medical/surgical, intensive care unit, obstetrics, etc.).

**Gateways for Recruitment**

My primary choice of gateway was through the American Organization for Nursing Leadership (AONL) which is the nurse leader leg of the American Hospital

Association. As a health communicator, I held associate membership within this organization, which is an option open to individuals who are not registered nurses but support the mission and vision of AONL. The mission of the AONL is to "Transform healthcare through expert and influential nursing leadership," and the vision of AONL is stated as, "Nursing leadership—one voice advancing health for all" (AONL, n.d., n.p.). According to AONL, access to the organization's membership for research participation is available for the purpose of academic and practice research that "conforms to the generally accepted norms and standards for survey research and informs healthcare leadership, workforce, or health services" (n.p.). To request AONL membership participation in the study, I made a request via submission of an executive summary of the research proposal, a copy of the survey (in this instance a Qualtrics interest questionnaire), proof of IRB approval, a release from liability for AONL, and language for publication on the organizational website (including a URL to the Qualtrics survey). Although this study is qualitative in nature and data collection took place through semi-structured interviews, I provided a participant interest questionnaire link (created via Qualtrics) to AONL and requested that the link to the participant interest questionnaire be published on their website under their "Research Participation Opportunities" web page. (The purpose of the interest questionnaire was to aptly screen eligible participants and ascertain their availability.) The organization published my announcement of this study for a reduced member fee. Additionally, as an AONL member, I posted a message on the AONL Leader2Leader Online Member Community discussion board, where the post was clearly labeled as "Request for Research Participation" and included a statement that the research was not under the control of or endorsed by AONL.

Although my first choice for recruiting participants was through AONL, other organizations also served as gateways for access. For instance, allnurses.com is a nursing career and support website and deems itself the largest nursing community in the world, comprised of nurses, educators, students, and professionals. The mission of allnurses is to "Empower, Unite, and Advance our members by providing a community where they can grow and succeed in their career" (allnurses website, n.d., n.p.). Several nursing niches are represented on the allnurses.com website via select discussion boards, including a discussion board targeted toward nurse managers. I completed a comprehensive application process and ultimately received written permission to post a request for participation (along with a link to the Qualtrics eligibility survey) on allnurses.com.

As a Certified Patient Experience Professional (CPXP), I also approached the broader patient experience community via The Beryl Institute and The PX Community. I posted a request and survey link on the website discussion board of The PX Community, a member-based organization (of which I am a member) that enables patient experience professionals to network and learn from each other. The Beryl Institute, a membership-based think tank that explores issues pertaining to patient experience, as well as an organization that partially funded this dissertation via a $1,000 scholar grant, also allowed me to post a request and survey link on its members-only discussion board. Finally, I was able to gain access to a dedicated Facebook group targeted to nurse managers and posted a request on that page.

Those who completed an interest questionnaire (see Appendix A) and subsequently agreed to participate in the study received a $75 Amazon gift card as an incentive.

**Sample**

In total, 25 nurses completed the Qualtrics interest questionnaire from early February to mid-May 2023. Although I did not track the specific gateways they used to find the research opportunity, I do know from participant comments that the survey was accessed from at least four of the five gateways, via AONL, The Beryl Institute, allnurses.com and The PX Community. In retrospect, tracking the gateways may have informed my research, as I would have been able to ascertain whether vast differences in nurse manager perceptions were associated with their respective affiliations.

Of the 25 who completed the interest questionnaire, one was deemed ineligible due to lack of knowledge about patient experience measures and was thus not chosen for an interview. Ultimately, 24 interviews were completed, though one participant was disqualified after the interview due to a misunderstanding about the eligibility criteria. Thus, the final sample consisted of 23 participants who completed interviews: 22 current or recent nurse managers and one assistant nurse manager. Those interviewed lived in 14 different states: New Jersey, Pennsylvania, Virginia, Maryland, North Carolina, South Carolina, Tennessee, Kentucky, Tennessee, Texas, Minnesota, Missouri, Ohio, and California.

All participants identified as female. Participants ranged in age from 31 to 59 years (mean age 44.4; median age 43) and had between 9 and 38 years' experience as a nurse (mean 19 years) and between 1 and 24 years' experience as a nurse manager (mean 7.6 years). Approximately 75% of participants represented large tertiary hospitals, and 25% represented smaller community hospitals. Of the 23 participants, 13 are or were nurse managers on medical/surgical units; 3 on transitional care units (TCUs); 1 on an intensive

care unit; 1 on a neonatal care unit (NICU); 2 on a labor/delivery unit; and 1 representing a children's hospital. Additionally, an emergency department nurse manager was interviewed, as well as a nurse manager for a system-wide float pool (this person is not directly accountable for patient experience scores, but she offered a unique perspective, as the float pool nurses and "travelers" that she manages are often blamed for less than stellar patient experience results). Of the 23 participants, 16 were white; 5 were Black; and 2 were of Asian heritage. One participant identified herself as white, though Hispanic in ethnicity.

## Procedure

### Data Collection

As mentioned previously, the initial solicitation of potential participants was conducted via distribution of a link that leads to a Qualtrics interest questionnaire (see Appendix A) that gauged eligibility and collected interview availability information. Upon completion of the questionnaire, participants were contacted via either text or email. Each participant received an informed consent document (see Appendix B) that further detailed the study (and their part in it), expounded on the confidential nature of the study and their rights, and detailed the financial incentives associated with participation.

Participants were then scheduled for a 40- to 50-minute semi-structured interview via Zoom. Ultimately, interviews ranged from 31 to 61 minutes in length, with the average interview length approximately 42 minutes. All participants verbally consented to the interview prior to starting the interview. Generally, the interview questions focused on nurse manager perceptions and attitudes about the patient experience measures in

which they were or are held accountable, the stress that is triggered by these organizational expectations, the ways in which they communicate to those above and below them about patient experience measures, communication challenges and breakdowns that occur, and the degree to which they experienced conflict because of expectations to earn acceptable scores (see Appendix C for the interview protocol).

The goal in discussing these issues was to treat the interviews as narrative occasions, with my end goal to draw personal stories about work experiences from those interviewed. Riessman (2008) explains that the goal of narrative interviewing is to "generate detailed accounts rather than brief answers or general statements" (p. 23). Tracy (2019) adds that drawing stories from individuals helps researchers gain deeper understanding and develop empathy for the experiences of others and that as these stories come more into view, they can better clarify realities that can, in turn, be acted upon. Tracy also emphasizes the value of interviews, as they provide opportunities for participants to provide their accounts, including "rationales, explanations, and justifications for their actions and opinions" (p. 78). Tracy explains that interviews are particularly valuable for gathering information that cannot adequately be observed or accessed. As a non-nurse—and particularly a non-nurse manager—I could not begin to fathom the true reality of the challenges they face in attempts to satisfy organizational expectations. Tracy (2019) also stresses that interviews are an appropriate and efficient means by which to "cut to the chase" to explore specific topics—such as with the topic of this dissertation.

**Interview Protocol**

Data collection took place via semi-structured interviews, which, contrary to structured interviews that stick to a strict list of questions, are more organic in nature (Tracy, 2019). This affords the interviewer some flexibility with questions and the opportunity to probe significant points that might not otherwise surface if respondents are limited to scripted questions. Tracy (2019) does warn that such interviews can easily swerve off the topic at hand and that more flexibility with the interview protocol could make it more difficult to compare data across participants. However, using an approach that stimulates discussion (rather than dictating it) offers more benefits than drawbacks in exploring this subject. In conducting the interviews, I used an interview guide (see Appendix C) that promoted collaborative dialogue and guided the discussion. The guide was somewhat malleable and was intended to be used as an interview roadmap that sometimes led to detours. According to Lindlof and Taylor (2011), interview guides allow researchers to eliminate questions that may not seem relevant to the individual interview, add questions, or simply improvise.

Although there was flexibility in which the interview proceeded, points of discussion were guided by the research questions that are posed in this dissertation. Questions were phrased simply and were jargon-free. The interview guide contained a range of interview points, with the course of the interview guided by the interview process offered by Tracy (2019). Tracy suggests the interview should begin by "breaking the ice." This includes setting expectations about the interview and establishing rapport so that the participant feels comfortable and unthreatened. After opening the interview, Tracy recommends generative questions that are non-directive (such as hypothetical

questions, asking about their own feelings, or other people's motives). From there Tracy suggests transitioning into more directive questions, which may be more close-ended and guide respondents to think within certain parameters (Lindlof & Taylor, 2011). This is the point where more sensitive questions could be asked—after rapport has been established. Potentially threatening questions are saved for toward the end of the interview. Closing the interview entails asking respondents if they would like to add information that had not already been discussed. Finally, Tracy (2019) suggests ending interviews on a good note with identity-enhancing questions that help respondents feel like experts on the topic and appreciated for their insight. These questions can be posed as, "What advice would you give…." or "What did you feel was the most important thing we talked about?" Their responses to these types of questions can also inform subsequent interviews.

I conducted interviews virtually via Zoom and used a personal recorder to record the interviews. Participants were informed that interviews were audio recorded for transcription purposes only and they would have the option to mute the Zoom video feature. Upon completion of the interviews, recordings were submitted to Temi.com for raw machine transcription. I then reviewed each raw transcript and compared it with the recording for the purpose of making corrections and redacting any identifying information (such as names of cities, places of employment, etc.). From this process final transcripts were generated.

**Pilot Interviews**

I conducted two pilot interviews. This process ensured a refined interview protocol. It also helped to make me, as a researcher, more cognizant of underlying or

hidden issues that I may have missed in my initial question set. The pilot interviews also determined whether the questions asked were indeed sufficient in addressing the research questions (and theoretical perspectives) posed. For the initial pilot interviews, my intention was to recruit at least one eligible participant who was "close to home"—that is, a current acquaintance or someone referred by current professional acquaintances. After completing the interview process with the first two interviewees, I assessed interview flow and sought additional feedback pertaining to gaps in the original questioning and recommendations for further questioning. Neither interviewee provided significant feedback that would necessitate a change in the interview guide, with both satisfied with the questions and the flow. However, from my own experience with the interviews, I determined that one significant change to the protocol was necessary with the initial "break the ice" question. Originally, I started interviews asking participants to describe a typical day. As such, they felt compelled to elaborate about every detail of a typical day. This resulted in time-consuming responses that yielded no significant usable content. As such, I changed the initial question from this to asking them to provide a brief background of themselves and how they ended up as nurse leaders. This yielded shorter responses and more time to get into the "meat" of the interview.

**Establishing Saturation**

Determining how many interviews is enough is always a dilemma that plagues those conducting qualitative research. Ideally, interviews will be conducted to the point of saturation, or the point where any additional responses gained will no longer add to the findings of the study. Of equal import is consideration of what type of saturation is targeted. Saunders et al. (2018) outlined four different models of saturation: *theoretical*

*saturation*, or where all constructs of the theory are represented by the data; *inductive thematic saturation*, which relates to the emergence of new codes or themes; *a priori thematic saturation*, or the degree to which identified codes or themes are exemplified in the data; and *data saturation*, or the degree to which new data repeat what has been expressed in previous data. Saunders et al. (2018) concede that not all qualitative researchers embrace categories that are so cut and dry, and instead employ hybrid forms of saturation that combine two or more models. For this study, I conceptualized saturation as an inductive-theoretical-thematic hybrid, where data collection took place to the point where the development of new codes or themes that related to the theoretical framework were exhausted and that the collection of additional data was not likely yield new insights.

Upon establishment of a conceptualization of saturation, consideration of an approximate number of interviews to conduct is in order. Tracy (2019) notes that it is near impossible to determine the point of saturation when data collection is initiated. As such, researchers should have at least an approximate number in mind of how many interviews they might need to conduct. Determining that number can be contingent on several factors, such as how narrow the sample is and the expertise of the participants. Some researchers claim that the point of saturation can be reached with as few as 10 to 12 participants (Guest et al., 2006; Small, 2009). In her literature review examining controversies pertaining to saturation, Sebele-Mpofu (2020) found there is no consensus whatsoever about adequate sample sizes for reaching saturation. She contends that those who favor small samples do so because they feel large samples may dilute the complexity of the data and impede rich analysis that would fail to contextualize the data. However,

others who favor larger samples contend doing so will ensure credibility of the data that will reflect diversity of opinions. Still, Sebele-Mpofu notes that some researchers take an "it depends" stance—that the size of the sample should be determined based on how homogenous or heterogeneous the sample is, where a more uniform sample would require a lower number of participants.

Although my plan to recruit participants from throughout the United States hopefully achieves a diverse sample that lends to transferability, the fact that my intended sample was so narrowly defined by profession and role yielded a somewhat homogenous sample. To guide my estimation of an adequate sample size, I reviewed a multitude of qualitative studies (many cited within this dissertation's literature review) that used semi-structured interviews to collect data from nurse managers. In 11 studies reviewed, the range of samples spanned from 8 participants to 40 participants, with the mean sample being 17.3 and the median sample at 15 (Anderson, 2015; Cao et al., 2021; Kodama & Fukahori, 2017; Marx, 2014; Leonenko & Drach-Zahavy, 2016; Miyata et al., 2015; Nicotera & Clinkscales, 2010; Roshanzadeh et al., 2020; Udod et al., 2016; Van Bogaert et al., 2015; Weaver Moore et al., 2015). Informed by these studies, I estimated that the point of saturation may likely be reached within 20 to 25 interviews. If not, I would have continued to conduct interviews until I exhausted the likelihood that additional interviews would not yield new and rich findings. This strategy ensured increased confidence in the findings. With this study, I determined that the 23 interviews I conducted reached or exceeded the point of saturation. I based this on my own experience conducting the interviews that after 18 to 20 interviews, new insights did not emerge. This suspicion was

confirmed during my initial coding process, as toward the end of my initial coding process no new codes were created beyond the 20th interview.

**Rigor**

Assessing qualitative research to ensure rigor is crucial. Daniel (2019) suggests that rigor can be demonstrated through the process applying four critical dimensions: trustworthiness, auditability, credibility, and transferability (TACT).

Using the TACT framework to establish *trustworthiness* (Daniel, 2019), one might ask the following questions:

- Is the research problem framed within the context of reviewed literature?
- Are the methods used for data collection appropriate for addressing the research problem(s)?
- How was the data analyzed?
- Do the findings accurately present the participants' perspectives?

Pertaining to this study, I felt the research problems very much aligned with the rationale presented through the literature review. Also, I have spent enough time in hospital settings with nurses to engage with the selected sample. My plan for data analysis included active categorization as described by Grodal et al. (2021), who assert that qualitative analysis is fundamentally a categorization process and that by effectively following a precise process, researchers can gain better understanding about how theory is generated from data. These researchers propose several possible analytical moves toward effective categorization. Among these activities are "focusing on puzzles," or focusing on the data that is most surprising; dropping categories with no theoretical traction; merging and splitting categories as deemed by the data; and developing or

dropping the working hypothesis depending on whether the data can build on the theory or yields unsupportive evidence. The authors express that "By being reflexive about their active role in confronting and creating categories, scholars can be more transparent about their choice of moves, and thus increase the rigor for their analytical process by making it easier for readers to assess their work" (Grodal et al., 2021, p. 604). This active categorization that includes thematic coding ensures rigor of the research. The selection of verbatim passages that reflect the themes and the act of member checking will help to ensure that the findings reflect participant perspectives.

Using the TACT framework proposed by Daniel (2019) to establish *auditability* would merit consideration of the following questions:

- How transparent is the data collection?
- Do the findings verify the research problems?

Data collection entailed documenting and verifying eligibility to participate in the sample and ultimate transparency regarding the terms of participation. Interviews were audio recorded and transcribed verbatim "for the record." The interview protocol, specifically guided by the research questions presented, yielded responses that directly address the research questions. Additionally, I used coding software to conduct first-round coding and then generated reports that detailed the entirety of the coded interview excerpts. Throughout the process I used a small notebook that helped me to process the initial codes and ultimately synthesize the 74 first-round codes into 15 larger themes. I also used the notebook to sketch my vision to extend SDT.

To determine *credibility* of the data and guided by Daniel's (2019) TACT framework, the following issues merit consideration:

- Are the methods used appropriate?
- Is the analysis of the data theoretically grounded?
- Do the findings add to the body of knowledge?

My selection of semi-structured interviews was warranted because, simply put, the angle pursued is one that has not yet been explored by the current body of research, and deeper understanding about why nurse managers may experience structurational divergence (due to accountability issues for patient experience scores) is needed. One of the primary goals of this study was to ascertain whether this is even an issue of concern. Determining this, as well as deciphering other issues raised by the research questions, is best accomplished via person-to-person dialogue that enables respondents to be forthright about their perspectives. One advantage to qualitative methods is that they lend to further theory development (Nowell & Albrecht, 2018). Ultimately, the qualitative nature of this research has the potential to advance SDT, or possibly clarify its aspects.

*Transferability*, as outlined by the TACT framework (Daniel, 2019), will consider the following questions:

- Are multiple realities acknowledged?
- Are the findings applicable to similar contexts?

The semi-structured nature of the personal interviews allowed enough flexibility in the interview protocol for unique perspectives (and possibly outlying perspectives) to be recorded, acknowledged, and reflected. Because the sample was narrowly defined to nurse managers across a variety of contexts, a possible challenge of this research may be that findings may not be specifically applicable in all contexts. However, although primarily explored within a nursing context, SDT has been studied within a few other

contexts (Bland et al., 2022; Eise & Rawat, 2021; Zanin, 2020), and it stands to reason that the investigation of structurational divergence due to accountability issues in general could transcend various contexts.

## Ethics

A study of ethical dilemmas in qualitative research by Ngozwana (2018) examined several issues that may be encountered, including withdrawal from the study and anonymity/confidentiality. As a researcher I viewed my own ethical responsibilities seriously, and wanted to make sure those I interviewed knew I admired their vocations, empathized with their challenges, respected their right to confidentiality, and ensured that they could feel safe talking to me.

The study's consent document (Appendix B) assured participants that their participation was completely voluntary and that they did not have to answer any questions that made them uncomfortable. Participants were also assured of the confidentiality of their responses and that they could mute video on the Zoom platform. Interviews were recorded for transcription purposes only. Upon transcription, pseudonyms replaced the actual names of participants, and I focused attention on ensuring that any interview excerpts published in the final study in no way identified the participants. I asked participants to engage in the interviews at a site other than their workplace (though not all did) to promote more forthright responses and ensure confidentiality.

## Data Analysis

Because scant research exists that explores nurse manager perceptions of accountability relating to patient experience measures, my goal was to gain deeper

understanding of these perceptions. I felt this could be accomplished through an inductive coding process, where the underlying themes would emerge from the transcripts. Although this may resemble a grounded theory approach, for this research I utilized what Tracy (2019) deems a *phronetic iterative approach*. Phronetic iterative analysis alternates between considering existing theories and research questions on one hand and emergent qualitative data on the other. Although I had initially drafted a few codes related to SDT prior to the coding process, throughout the initial coding process I examined data and largely created codes inductively from the data. During the whole process, code creation was guided by the components of SDT.

After the transcripts were generated (totaling more than 400 pages) and finalized, I initiated first-round coding and immersed myself in the data. For the primary cycle coding, I used Quirkos qualitative analysis software to review the transcripts and perform active categorization and thematic analysis to generate codes, categories, and themes. Tracy (2019) explains that many use the term "code" for more descriptive words, while "themes" or "categories" are more theoretical labels. According to Riessman (2008), thematic analysis—where content is the exclusive focus—is the most common form of narrative analysis. And unlike grounded theory, thematic analysis uses prior theory as a resource for the interpretation of the narratives. Thematic analysis is a straightforward and popular approach in processing research interviews and has been used often in studies of nursing and other healthcare professions.

Initial analysis yielded 74 separate micro-level codes (see Appendix F) and 140 pages (in 10-point Calibri font) of coded excerpts. During the second-round, or axial coding, phase I was able to identify patterns of codes and merge codes into fewer

overarching categories (approximately 15) that were evenly split to address the three research questions (see Figure 2 and Appendix G for a breakdown of themes). Tracy (2019) refers to this as hierarchical coding, where codes are "grouped together under a hierarchical umbrella that makes conceptual sense" (p. 226). As the hierarchical codes and accompanying sub-codes were finalized, I proceeded to match interview excerpts with their accompanying categories and conduct a final review to ensure that the themes gleaned from the transcripts were accurate.

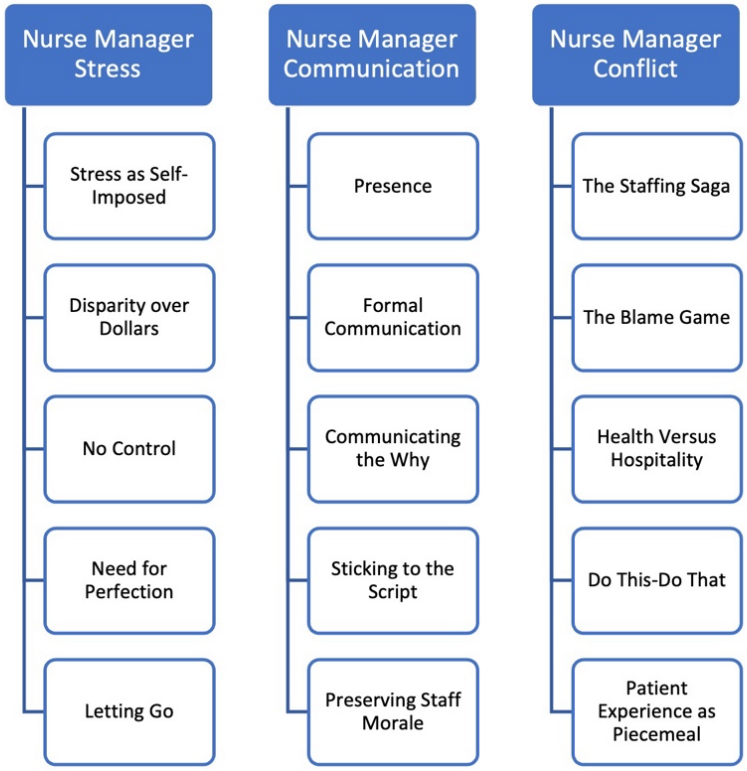


Figure 2: Thematic Chart

**Member Checking**

To conduct member checking, I composed a summary of findings and provided this summary to respondents for their thoughts and feedback. I randomly chose member

check participants from the pool of respondents. Member checking gives participants the opportunity to evaluate the "truth" of a study's findings (Lindlof & Taylor, 2011), thus giving the opportunity for participants to weigh in on whether findings are accurate or whether there are areas of dissent. I carefully considered any dissenting remarks, though it did not guarantee that changes were made as a result of these dissenting remarks.

Among the six interviewees I contacted, four responded and agreed to review a 13-page summary of my results (consisting of the abstract, the themes that emerged, and sample quotes to illustrate the themes) and provide feedback. Specifically, I asked them to answer four questions, as recommended for member checking by McKim (2023):

1. After reading through the findings, what are your general thoughts?
2. How accurately do you feel the findings captured your thoughts/experiences?
3. What could be added to the findings to capture your experiences better?
4. If there is anything you would like removed, what would that be and why?

Generally, the respondents agreed with the summary of my findings, indicating that the research aptly captured their feelings. One respondent recognized the pseudonym I used for her and provided minor clarification of one of the quotes I had used in the summary. Another respondent noted that the research was valid, yet "not surprising." Two other respondents felt the research validated their own experiences and appreciated how the research findings showed that these issues span across many different organizations. One expressed, "It feels good to see that so many of my thoughts and concerns are shared by others in my role." One constructive suggestion, however, was that more background about how patient experience surveys are developed, particularly as they pertain to considering patient input, would have been helpful. Another suggested

that this research could be complemented with a qualitative exploration of staff understanding and perception of patient experience. (I agree with this assertion, given the numerous comments from interviewees that staff did not understand the "why" of patient experience. Thus, this could be a topic ripe for further exploration and possibly a logical next step for extending this current research.) All respondents said that they appreciated the opportunity to review the summary of findings and thanked me for including them in this research.

To summarize, I believe that my selection of a qualitative methodology gave me the opportunity to gain valuable insight about the research questions presented in this study. All in all, the nurse managers interviewed were eager to share their experiences about how they manage their accountability for patient experience scores. Most of the interviews were more conversational in nature and less formal. As such, I found the conversational approach generated rapport that contributed to the organic nature of these conversations.

The next chapter will detail findings from the research, particularly pertaining to the various themes that emerged from the interviews.

# CHAPTER FOUR: RESULTS

I feel that those who assume nurse manager roles undoubtedly do so because of a desire to lead, or an inner sense of calling that they must lead. Leading in such a way has the potential to be enriching, if for no other reason than to know that the role is integral in making a difference in people's lives. However, with the rewards also come many challenges, including the traditional challenges of dealing with staffing and turnover. This research explores nurse manager experiences being accountable for their units' patient experience results. Findings suggest that while this accountability was not often revealed to be at the top of the list of stressors, most participants did indeed feel they had experienced some level of stress trying to manage patient experience scores (RQ1). Findings also indicate that although formal communication and coaching processes are in place to address scores, opportunities exist to enhance these processes (RQ2). Finally, nurse managers shared their feelings that conflict occurs from senior leadership expectations to obtain desirable scores, including nurse manager perceptions that they and their staff have no voice to suggest solutions; that nursing units often receive the blame for less than optimal scores without any shared accountability from other ancillary departments; and how the laser focus on just the scores can result in more tasks for staff nurses that, ironically, impedes the ability to view patient experience more holistically in the care process (RQ3). In this chapter, I outline the findings regarding each of the three research questions guiding this study, providing data from the interviews as exemplars to thresh out the relationship between patient experience scores and nurse manager stress, communication, and conflict.

### RQ1: Patient Experience Scores and Nurse Manager Stress

Nurse managers shared that they do indeed experience stress at varying levels due to management expectations to obtain desirable patient experience scores. Olivia, a veteran nurse with more than 20 years' experience as a nurse manager (tertiary hospital, medical-surgical unit), shared how it can sometimes be hard to have so much on the line over patient perceptions and the intense pressure to come up with quick fixes:

> It's hard to say I don't stress over it. Because it just feels like, God, like your job is on the line a lot of times. And I, it's a very ugly feeling because again, you think you don't see all the good things we are doing and you focus on someone's perception that, you know, maybe it is valid, but sometimes it's not. It's horrible to sit in a meeting in front of everybody and get pinned. (We're) all overshadowed because we couldn't get to the number that they wanted.…So that was very stressful to me because every week you had to be, you had to meet with administration (who says) why aren't your scores up? What are you doing? And you're thinking, nothing changes in one week—I'm sorry.

Riley, a veteran nurse (more than 20 years' experience) with more than ten years' experience as a nurse manager (community hospital, medical-surgical unit) echoes that the pressure is real, particularly with overall hospital rating rankings, where on the scale from zero to ten only nines and tens count (essentially meaning that even an eight is as bad as a zero):

> You want your patients to be satisfied. I don't want to have low scores. You know, we're in that middle ground there. You know, a lot of eights. (If we could) just move a couple of those up, we'd be in better shape. (The stress) kind of goes with the job. So whatever kind of stress you have, we eat stress for breakfast.

Ursula, a veteran nurse with approximately eight years' experience as a nurse manager (tertiary hospital, medical surgical unit), puts stress into perspective and concedes that stress is less intense when the scores are good:

> I think the stress, it gets to me, but I think there are other things that stress me more. And I think knowing that we are talking about it and knowing the scores where they are, it doesn't stress me as bad now. We're at a good place right now.

Findings indicated that stress associated with patient experience scores was experienced in various ways, from stress being self-imposed to stress over the measure itself. The following examines the many variants of stress that results from managing patient experience scores. Themes that emerged included self-imposed stress; financial concerns; no control over the results; unrealistic expectations by management; and change as a long-term process.

**Stress as Self-Imposed**

Several nurse managers indicated that, by nature, the role of nurse manager is most often occupied by Type A personalities. In other words, nurse managers tend to be high achievers who are ambitious and, to a degree, competitive. As such, the pressure to perform is self-imposed. Joanna, who has approximately two years' experience as a nurse manager (tertiary hospital, medical surgical unit), describes it this way:

> It's not about the staff, it's about me. It stresses me more because I want to keep the high expectations. It's just, you know, I need to work hard. I need to find different ways. I need to look at the literature, see what's been done that maybe I can implement on our unit.

According to Quinn, who has 10 years' experience as a nurse manager (teritary hospital, medical-surgical unit), pressure to earn optimal patient experience scores is spurred by a genuine desire to serve the team working under her and the patients themselves:

> It is a lot of pressure as a leader. You do want to have success for your team. You know, it's more about them, but also ultimately, it's about really being passionate about what you do, wanting to take care of these

> patients, help them feel cared for, or give them a good experience probably during the lowest points of their lives.

Holly, a veteran nurse with approximately 20 years' experience as a nurse manager (community hospital, medical-surgical unit), concurs that the desire to succeed in managing the scores brings about stress to achieve goals:

> Just knowing what you have to do as far as, you know, you have your goals set, and so if you know you're not leading that goal, that's stressful in itself. Even though it's a year-end goal, but month after month leads up to that year-end goal. And so you have your goal, and then your senior leaders have their goals. You know, do they marry? Do they mesh? If they don't, that's stress in itself.

Wynonna, who has four years' experience as a nurse manager (tertiary hospital, medical-surgical unit), says that she had quite a bit of self-imposed stress as a new nurse manager and was so eager to manage scores that she wasn't as focused as she needed to be to improve them:

> I wanted to do everything to fix the scores and to get better. And to make improvements for our patients because I was ultimately like, oh my goodness, we're not providing quality care if our scores are showing that low. In doing so, I kind of took all the evidence-based practices out there and tried to implement them. I think because I was under so much stress, putting it on myself, I didn't pick out what was most important. I picked out all the best practices and tried to implement all of them instead of focusing in and really making it more impactful. And I think because of that, because I wasn't streamlined in one direction, I really burned myself out pretty quickly.

Several nurse managers spoke about how they would take low scores personally. Latosha, who has slightly over two years' experience as a nurse manager (tertiary hospital, medical-surgical unit), explained her feelings this way:

> As a nurse manager, you are sort of measured, if not directly, indirectly by your HCAHPS scores and how well you are doing on (the) unit. You may think that it's all on you, because you are the one who has to present these numbers to the upper-level management. We also need to engage our staff and make them understand they have a huge impact.

> So it was challenging for me initially to not take these things personally. But I still struggle at it every day because I think it's a reflection of how I run my units.

Although much of the stress that nurse managers feel as it relates to patient experience scores is self-imposed, this stress materializes in other ways, including financial concerns.

**Disparity over Dollars**

As indicated in the literature review, patient experience scores are tied to insurance reimbursements, particularly by Medicare. Thus, low scores translate to less revenue for hospitals. Hospital senior leaders are aware of this. As such financial incentives for nurse managers and sometimes their staff are tied to how individual units perform. Adele, who has only been a nurse manager for approximately one year (community hospital, medical-surgical unit), expresses her frustration about this process in this way:

> I mean, I do believe that we look at scores because it's what's absolutely best for the patient, but like, deep down, knowing that it comes down to reimbursement. And that the government has really kind of put us in this kind of situation is really, really kind of aggravating.

Inga, a nurse manager for approximately eight years (tertiary hospital, transitional care unit), points out that sometimes staff do not understand financial ramifications that can come about due to low scores:

> I had to kind of sit down with them and just put it into plain language – let's sit down and see how this impacts you. I did talk to them about the patient satisfaction bonus. I just told them, look, we missed the goal. Our satisfaction bonus for the entity if we hit our goal. Like our money will be more. Isn't that what you want?

Evie, who has approximately seven years' experience as an assistant nurse manager (community hospital, transititonal care unit), explains that low scores can result in a domino effect when it comes to consequences:

> If I don't worry about taking patient experience into consideration, if I'm just doing my job and then the hospital's losing money because the scores are down and the community's losing faith because everything online says "oh, that's a horrible place to go." If all those things are happening because I don't care about patient experience, eventually there's not really the money to pay the staff. So then we look at more staffing issues. There's not money for equipment. So then things are broken or we just don't have it anymore. So there's many financial ties to those scores. If you break it down, it provides our equipment, it provides our supplies, it provides our salaries. So I think breaking it down like that helps.

Self-imposed stress, coupled with concerns over dollars, are significant factors contributing to nurse manager stress over patient experience scores. But probably one of the most significant sources of stress is knowing that so much that is contingent on receiving good scores is out of a nurse manager's control.

**The Toll of No Control**

Most of the nurse managers interviewed expressed frustration that patient experience scores were often numbers they could not control. Specifically, many complained that—unlike quality measures such as tracking falls or hospital-acquired conditions, quantifying experience is nearly impossible because perceptions are so subjective. Still, at the end of the day, everything centers around the number. Adele admitted that worrying about the scores was one of the most stressful parts of her job, "just because it is something (where) I don't have a lot of control."

### *Patients Don't Understand*

One concern that was often expressed is that patients themselves are not familiar with the measures, or even that the measures exist. Even if they are aware, they do not understand the stakes—that the hospital's reimbursement rates are entirely contingent on the rankings received and that when an overall hospital ranking is assessed, only the nines and tens count. Fiona, a veteran nurse with seven years' experience as a nurse manager (tertiary hospital, obstetrical unit), indicates that she is often tempted to clarify the process to patients—as they do not know the significance of top box scores—though the rules of the survey forbid coaching patients to influence their responses:

> I'd love to say you're going to get a survey, and if I don't get a nine or 10 I would like to know why I'm not getting that now. Otherwise, don't even bother to fill out the survey.…The biggest part of this is the patient, who we leave out. It's reimbursement. The patient knows nothing about reimbursement. For them it's a contract between, you know, Aetna, United Healthcare, Blue Cross/Blue Shield and whoever their employer is.

Several nurse managers shared that many patients do not choose top box scores on the survey, not because the care wasn't good, but simply because of their own biases and perceptions that nobody is perfect and there is always room for improvement. In other words, the choice is completely subjective in that one person's 10 might be another person's eight. Deirdre, who has seven years' experience as a nurse manager (community hospital, obstetrical unit), concurred:

> You can have a perfectly great experience and give it an eight because, you know, there's always room for improvement, but the fact that it's weighted that way (means) that an eight is essentially, you know, a zero.

Not only are patients not aware of the significance of top-box scores, many nurse managers were concerned that patients find the language of the survey confusing and might not understand it. Evie took issue with the literacy level of the survey:

> I put together this checklist and was looking at it with (the) education (department), and they're like we have to have this at a fifth grade reading level. And I'm like, okay. I pulled up the survey and checked the reading level of some of those questions, and they're college level. And I'm like, you expect me to present this to the patient in a way they understand at fifth grade level, and then you're gonna ask them how I did at a college level?

Furthermore, Evie shared a recent experience where wording, particularly the word "side effects" (a term that is mentioned in the HCAHPS survey), was confusing to a patient:

> I overheard this nurse (who was taking care of a patient), and she's like, "hey, you're taking this antibiotic for infection." (The patient was) like, "oh, okay." And (the nurse said) "it might cause you to have diarrhea." So I'm listening to this. And then I think it was later, or it was the next day. I go to the same patient and say "did they talk to you about your medications," knowing that yes, they did. And he (the patient) said "sure." I said, "did they tell you what the purpose of the medication was?" And he said, "I think I have an infection." I was like, "okay," so I checked that mark. I said, 'did they tell you about the side effects?' And he says 'no, they didn't tell me about the side effects." And then, kid you not, he's like 'oh, wait a minute, I gotta go to the bathroom." And he runs into the bathroom, and he says, "the nurse said I might get diarrhea." And I was like, "that's the side effect." But because the nurse didn't say the word "side effect." Instead, she said, "This may cause…" And so when patients hear (that), they don't equate that with a side effect. And so when they take the survey, they don't know (the word) side effect.

This represents just one perceived flaw with the measure. However, it was not the only perceived flaw with which nurse managers took issue.

### *Concerns about the Measure*

Nurse managers were concerned about the validity of the measures, as they felt that the concept of patient experience is far too subjective to be quantified. In other words, nurse managers questioned how perceptions can be tied to a number. Sandy, who has seven years' experience as a nurse manager (tertiary hospital, medical-surgical unit), opines:

> Being at the level that we are, we're with the patients, we're with the staff. We see what's going on daily, and we understand it's always gonna be data, and we need to trust data because data is how we make changes or move forward. But it's not always black and white.

Holly agrees that the survey does not always accurately measure patient experience:

> My patient experience is what I believe it is, right? As a nurse, I feel as though I've given you the best care. But if you don't believe I gave the best care, then that's your experience. My experience is different from your experience. So again, I don't think (the survey) necessarily measures the accuracy of patient experience.

Navaeh, who has three years' experience as a nurse manager (tertiary hospital, medical-surgical unit), concedes patient experience surveys are useful accountability tools, but only to a degree:

> I think it's good that I'm held accountable for my unit and my patients' scores. However, I don't know that it's always a true indicator of the patient's true experience. It's their perception on the question, how it's asked, and what frame of mind they're in when they are taking the survey. They could be in a different frame of mind in the hospital, and then they might think about it later or have experiences with someone else when they take it. So there's definitely some subjectivity there.

Inga feels that if nothing else, the system for assessing overall hospital rate should be revised:

> To me, eight is still a better number than the person that would give me a one. You know, I'm not going to chase that one. But if it was the eight, you know, if I can convert the eight to something else… I'm focusing so much on like, why did they give me an eight?

### *Survey Timeliness and Length*

Many nurse managers were frustrated because they feel survey results are distributed after the fact, sometimes weeks after discharge, with some scores not becoming available until 2 or 3 months after patients have been discharged. Thus, it is hard to act on months-old feedback. Additionally, nurse managers are concerned that because patients receive surveys days or weeks after discharge, their recollections of their care may not be accurate. Ursula indicated one such hypothetical situation:

> (Patients are) exhausted, they're overwhelmed. And so when they do go home, they're like oh my gosh. They're so overwhelmed with all the discharge information and it's like, now what do I do? They're so overwhelmed when they're leaving here that they don't hear half of what you say. So you're like, okay, at what point in time are they filling out the survey? Are they still overwhelmed and tired? And so a lot of those factors are out of our control.

Additionally, several nurse managers mentioned that patient experience surveys are so long that they lead to respondent fatigue (such as with phone surveys) or the vast quantity of questions may dissuade patients from completing the surveys at all. (Although the actual HCAHPS survey is only 29 questions, most hospitals add additional "loyalty" questions to the survey that can more than double the survey size.)

To the point of the survey length, Riley feels that it would be best to streamline the survey:

> That would make it more meaningful for sure. And I think they could word them differently to maybe just focus on the things that really matter.

### *Environmental Factors*

In addition to questions regarding communication practices, the HCAHPS also asks patients about their perceptions of the environment, such as the level of quietness. Nurse managers felt that much of this was also out of their control. Riley provided such an instance:

> Was it quiet at night? Well, I mean the demented guy that lives on my unit that's been there for three months and screams all night – probably not, right? But that's nothing I can control or help you with. Sure, we can troubleshoot and try to make that better for people. But, should that be tied to CMS dollars?

Evie not only concurs with this sentiment but also notes that she occasionally gets pushback from her staff about environmental factors that are out of their control, and as such, they become resigned to not always being able to resolve issues:

> I would get much more pushback from them on the quietness because—and I don't know if it was so much pushback as it was excuse making. But it was like, well, we can't help this or we can't help that. And because we can't help that it's a semi-private room and we can't help that the IV beeps too loudly, we're not going to do anything to help. It's like, what we're doing is not gonna make a difference, because we can't change these big things.

### *Low N-Sizes*

Research indicates that units that experience higher response rates on the patient experience surveys tend to score better (Godden et al, 2019). In this vein, several nurse managers complained that low response rates (N-sizes) skewed their scores more negatively. The concern about response rates is valid, as research shows response rates for patient experience surveys have fallen over time, from 33% in 2018 to 26% in 2017, representing a .8 percentage drop per year (American Hospital Association, 2019).

Billie, a veteran nurse with 11 years' experience as a nurse manager (tertiary hospital, transitional care unit), mentioned this challenge:

> We discharge 160 patients every month, but then I only have about 12 people return the survey. Less than 10%, so my score is not really a true reflection of our work.

### *Scores Are Inconsistent*

Nurse managers were often puzzled about why the quantitative scores generated by the survey do not match up with the care that they know they provided or with the conversations they have with their patients. Adele describes it this way:

> Like, you think you're doing great and you're rounding, and everybody tells you you're great. And then you get your scores and you're like, where did that come from? It doesn't always match, you know. It's not always congruent with what I was hearing in rounds.…Sometimes you read the scores and you can see that they gave you an eight, yet they're some of the best comments you have ever seen. And you're like, these comments don't equal an eight. They (patients) name people of how great certain staff members were and talked about people going above and beyond. And then you look and it's an eight and you're like, dang.

Evie admits that it can be disheartening to see scores dive, particularly when intense efforts have been put forth to boost scores:

> The nurses I work with and that work for me, their hearts are in it for taking care of people. And so it's hurtful at times to see they've put forth all this effort and scores didn't budge. Or (they) went down and it almost feels a little defeatist…Scores go up and down—it doesn't matter. We didn't change anything this quarter. We're still the same people this quarter. Our scores are great, and the next quarter it's…we do the same thing. We didn't change anything.

Wynonna indicates that sometimes a simple thing that is beyond her control can skew scores. She shares one such instance where a patient provided lower than desired ratings and she was able to follow up with the patient to find out more:

> That patient, when I talked to him on the phone, had such wonderful things to say about the care that was provided here. But (with) the

> survey, we basically got zeroes all the way down. They gave such a bad score due to a stress test they were unable to get as an inpatient. And I was like, now that survey stays with me forever.

Often, nurse managers and their staff rely on the survey's narrative comments to gain insight. Although nurse managers appreciate the insight that they gain from the narrative comments, they largely agreed that in most instances the comments are viewed by organizational leaders merely an afterthought, as senior leaders tend to give less credence to comments in favor of the raw numbers. Despite this, nurse managers often find the comments valuable, as they provide more specific insight. Navaeh is quite straightforward about this:

> It's the numbers. Always. But I think it's just, at least for the frontline staff and the staff I'm leading, trying to show them what those mean and where that's coming from. So I like to show those comments. But yeah, it's strictly the numbers.

Evie agrees that the numbers are the priority:

> I feel like our senior leadership is definitely focused on scores because it's tied so much to reimbursement, and so many other things like five-star ratings and those kinds of things. They definitely talk to us when the scores go down and when the scores go up. The communication when the scores are going down is a little more, what are we gonna do about this?

Deirdre echoes the sentiment that senior leaders give little credence to the comments:

> Senior leadership, probably not. Because, you know, that's not the focus. CMS and Leapfrog (safety ratings assessed by The Leapfrog Group) don't look at patient comments. They look at the scores.

Ming, who has slightly over a year's experience as a nurse manager (tertiary hospital, emergency department), stresses that value can be found in the comments, but usually as a follow-up after reviewing the scores:

> Sometimes the comments are very telling because someone still will rate us the best hospital but give us very direct comments about areas where we need to improve. But we definitely look at the lower scores first. We tend to have a lot of middle of the road (scores) like fours, fives, and sixes.

**The Flawed Path to Perfection**

Nurse managers indicated that they feel stressed by senior leadership expectations for near perfection, if not perfection itself. But perfection—if attainable at all—takes time. As a relatively new nurse manager, Inga speaks to how she wasn't even adequately trained to address patient experience issues. She indicates that the extent of her training was receiving a copy of *Hardwiring Excellence* (Studer, 2003) and given the directive to read it:

> So my director is all like, "okay, I want you to read this book." I have it there in my backpack. I'm like, "okay—fine." But Studer makes it easy, right? But patient experience is getting like so fucking complicated. What's frustrating to me with HCAHPS is that as a manager, I was never really trained.…I am in a position that I feel like I do not have the tools as a manager. I feel like the expectation is really set high. Like it keeps me up. I know being a manager is stressful already to begin, and, you know, to add that extra pressure. My unit is the only medical surgical unit that is below target. That's too much on a new person who doesn't know anything about HCAHPS.

Nurse managers who are versed in patient experience concepts also experience stress because it seems that good is never good enough. Even with good scores, pressure to sustain them exists, and organizational expectations are that the good scores will get better. Ursula describes the pressure this way:

> This year I know our score will go up even more because of how we've done this year. So I know I'll be stressing about that for a lot of months. I see that we're over that hump and we're starting to come to the finish line. And then, so I'll be stressed about that. Are we meeting (the goal)? What are we not doing? Because every year the expectation goes up even higher. I think (senior leadership) saying okay, you're doing excellent and we would like for you to maintain that and that's

> your goal. But instead it's like, oh well, you're at 99 (percentile). We want you to be at a hundred this year.

Coupled with the stress to attain the most optimal score is the stress to do as well or better than other units within the hospital. Holly feels such competition can be nerve-wracking:

> I've been in situations where I've had to report out, you know, what my scores were, and then what am I doing to either maintain that score or bring the score up to where the goal is. You know, so that can be tense. If you're in a group with your peers and you know you're not measuring up to where they are, or you're doing better than they are, it can be tension either way.

Navaeh poses a different perspective, indicating that competition among units may not be so bad:

> Of course, I was always nervous, but I felt like it always kept you on your toes.…So we'll see in the organization where our unit falls and the six weeks compared to all the other units in the hospital. So it becomes a little competitive. We want to be above the line. We want to be in the green.…They always see what our overall rating is, and if it's in the green, we're good.

Wynonna, like Navaeh, concedes that competition from within may be scary, but that she herself is energized by it:

> I think sometimes people are scared to post your rankings within the hospital—my unit versus the unit next to me. But sometimes I think friendly competition is good and I think sometimes posting that is a good thing. I think it gives more accountability. I was always searching for where I stand amongst everybody else.…I'm a very competitive person, so I think I always wanted to be better than others because I was like, we can do better than that.

**Letting Go**

Although a few nurse managers indicated that patient experience scores were not a huge source of stress, these nurse managers typically represented units where patient experience scores tend to trend higher—such as pediatric and obstetrical units. Most

nurse managers interviewed expressed that pressure to manage patient experience scores presented at least a mid-level of stress on the spectrum, with a few indicating it was one of their highest sources of stress.

As stressful as this may be, nurse managers also conveyed that there is a point where the scores should be taken in stride. According to Billie:

> I would say the score is only one way to evaluate overall performance. You know what you do well or what you need to improve. Take it as a tool (and don't) let it control you.

Many of the nurse managers interviewed indicated that when it comes to scores, they have to not focus so much on what they cannot control and resign themselves to focus on what they can control, regardless of whether it makes a difference in patient experience scores. Ursula explains that sometimes the best way to deal with the pressure is to steady the pace in lieu of trying to bring about quick results:

> I always tell (staff) we will only work on the things that we can control. If we have no control, we just figure it out and make it work. So we just have to suck it up and go with it.…I think setting some of the goals and stuff are unrealistic. I feel like I'm being set up for failure. And I just take a deep breath and go, okay, you have an amazing team. You have tons of different resources….Let's see what options we have so you don't feel so overwhelmed. And we'll just start nibbling on the elephant, because I'm really bad about trying to eat the whole elephant at one time.

Ming feels that the fluidity of patient experience scores needs to be taken into account and that rather than going for a perfect score, she is content as long as she's at least moving forward:

> Don't sweat the small stuff. Kind of take it as it comes. You're never going to be 100% perfect. You could have a great year for patient experience and take a dip the next. And that's okay. Like we're ever changing. As long as you are working on forward motion or you know, if you don't know something, say it. If you don't know how to improve something, say so, so that you can get the help you need.

Holly echoes this sentiment, indicating that real change takes time:

> There were times, you know, where I felt like we weren't moving anywhere as far as in the positive trajectory. And I just couldn't figure out what we could have done differently. But again, you know, if you want change to happen, change doesn't happen right away. You have to have that understanding as far as change theory, it takes time. You've got to give it time to work, and then tweak it, and then do it again, over and over again. And again, you have to understand the change yourself as a leader. And you have to be able to communicate change effectively to other people.

All in all, nurse managers' comments adequately addressed the question posed by RQ1 about the relationship between patient experience scores and nurse manager stress. The themes that emerged indicated that the stress generated from their accountability for these scores can be self-imposed because of nurse managers' own tendencies to be high achievers, but much of the stress is generated because they feel they have no control over the scores.

The stress they experience from this accountability may influence the way they communicate about patient experience goals. Communication is indeed a crucial element of patient experience, as is indicated in the prior literature review. The next section will explore how patient experience scores relate to communication (RQ2)—current practices, as well as nurse manager perceptions of what is lacking.

### RQ2: Patient Experience Scores and Communication

A significant portion of the HCAHPS asks patients about how often hospital staff communicated to them in the hospital—whether it be nurse communication, communication about discharge instructions, or communication about medications. For instance, the line of questioning about communication with nurses asks patients to indicate the frequency with which nurses treated them with dignity and respect; how

often nurses listened to them; and the frequency with which nurses explained things in ways that could be understood. Nurse managers expressed that the nurse communication questions are areas that they can control. Other areas of questioning, such as questions that ask about doctor communication and questions that inquire about patient perceptions of environment (e.g., cleanliness, quietness) are less controllable, and assessments of overall hospital rating (the metric of which many hospitals base financial incentives) could be based on many components that are not necessarily in a nurse manager's control. This study explores how nurse manager accountability for patient experience scores impacts their perceptions of communication throughout their hospital organizations. In examining this question, themes that emerged included presence; formal communication channels; communicating the "why" of patient experience; coaching about keywords; and staff morale.

**Presence is the Essence**

Nurse managers agreed that one of the best ways to promote patient experience best practices on their units was to model the desired behavior that they wished to see. Sometimes, though, competing priorities—such as administrative duties—get in the way.

***In the Middle***

Many nurses expressed that their roles as middle managers were exactly that—roles that often had them caught in the middle between the needs of their staff and senior leadership priorities. Fiona succinctly put it this way:

> You can either be hated by the people under you, or hated by the people who you work for – it's a toss-up.

Quinn elaborated about what it is like to be in a role where she often feels conflicted:

> You're sandwiched in the middle between what your team wants and the pressure they're (senior leaders) putting on you, and the balking at new ideas and concepts, not embracing change.…You know, you have all that dynamic over there, and then you've got the expectation over here, and you just feel sometimes like you're out in the ocean without a breath.

Although nurse managers are often "in the middle," another concern is a realization that they are not omnipresent. In other words, due to their own management responsibilities, they cannot be in all places at all times. When asked whether presence makes a difference, Quinn replied:

> I do, to a degree. But I believe it has to be a healthy balance. You can't be out on the floor 24/7 because the fact of the matter is you have schedules, you have payroll, you have leadership meetings, you have the tasks that you have to do. Helping (staff) be able to see that—that is also a challenge.

Because it is impossible to be on the unit around the clock (particularly nights and weekends), nurse managers indicated the advantage of having strong team leaders on the unit. According to Adele:

> My team leaders, they're fantastic. Just make sure that they have the same goals and expectations as I do—so staff can see that when I'm not there.

### *Modeling Behavior*

Despite the lack of omnipresence, nurse managers by and large agreed that if they want staff to respect their directives and embrace patient experience concepts and practices, it is crucial that they themselves model the desired behavior—behavior that requires a great degree of visibility on the unit. Often, this means that all hands are on deck. Riley explains:

> Be out there and interact with your staff and interact with your patients, and be present. Because you learn a lot more from being in the midst of things. Go pass meds on some patients. Just go help out and just get out and listen to your staff when they're in the rooms.

Tessa, a veteran nurse who is a relatively new nurse manager with a year's experience (tertiary hospital, transitional care unit), concurs:

> In the morning I like to, you know, a couple of times a day get out of my office and just walk around. I also have the motto like a no-pass zone. So if a call bell is going off, someone's got to go in (to the room)—you don't pass by. So that includes me. I will go into the patient's room and ask them what they need. I want to model that behavior so (staff) will do it as well.

Ursula also considers herself proactive in establishing presence on her unit:

> I start going to individuals and saying, "Hey, what can I do to help you?" I'm out in the middle of everything with the staff. This morning I was rounding with them and there was a patient that needed something, and I grabbed someone else. I was like, "Hey, can you help me in here?" Though it wasn't her patient.

### *Rounding on Staff*

In addition to the importance of nurse manager visibility, many nurse managers asserted that they have an "open door" policy anytime that staff need to talk or express concerns, or that they will walk on the unit and have informal on-the-spot conversations. However, only two nurse managers described a process for formally rounding on staff (that is, periodically meeting one-on-one with staff to check in). According to Ming:

> Myself and our medical director, we round once a month together on staff. Currently we are working with my vice president on what rounding tool makes sense. We want to kind of incorporate it a little bit more on not just trying to influence them, but (to find out) do you have the tools you need for the day? Is there anything that is missing? How's it going?

When asked how the organization prioritized rounding on staff compared to the expectations for rounding on patients, several said that patient rounding was the priority. Joanna admitted that rounding on staff is not so much of a priority:

> On patients we do almost 500 rounds a week. On the staff—we barely do three or five for the whole organization.

Nurse managers expressed a desire to do more formal rounding on staff and feel there would be value in the practice. This is because staff may hesitate to approach their nurse managers, despite an open-door policy, because they think their managers are too busy to talk. About rounding on staff, Riley—who tries to round on staff monthly or quarterly depending on the number of staff on the unit, describes this scenario:

> Actually, I felt like I got more out of it than rounding on the same patients every single day (when the patients) had no issues. So (rounding) was a nice, prescribed way. I see them all the time, you know. I'm accessible and approachable and they can talk to me anytime they want to. But—it's almost how patients think they don't want to bother (staff) because they're busy. Staff think the same thing about the manager too. Making time for them, I felt like that was a meaningful thing, and I had meaningful conversations and found out things about my staff that were important or maybe helped me understand things better than I thought.

Holly's experience is that some staff may regard nurse manager rounding on staff as a punitive process, which she says is a perception that needs to change:

> Sometimes when nurse leaders come on the unit, the staff think, "okay, what do we do now or what are they looking for?" So we have to change that culture and that mindset of staff, and truly have them understand that we're there to leverage their strengths and to help them strengthen weaknesses as well. They're the face of the unit, right? They're the face of the hospital, of the organization. So we have to make sure that they understand that they are very important, and they are the drivers of patient experience.

Joanna concedes that there should be more focus on staff, but that is not necessarily the reality:

> Focus on the staff because they are the frontliners and they are the ones working with the patients. Do not focus on the patients themselves. I think these days we focus more on the patients, just like me. Like I go do my leader rounds on patients and I get the feedback from the patient. But we don't listen to our staff very often.

In addition to a lack of formal systems to round on staff, nurse managers frequently expressed concerns that senior leaders needed to be more visible to staff on the front lines, to figuratively walk in their shoes. According to Navaeh:

> I had the CNO come to some staff meetings. Some people didn't even know who she was. Our CNO will come around every now and then and talk to people. She'll give out candy and she'll say hi. But other than that, I don't know that they (senior leaders) have a good gauge on what's going on in these units sometimes. (On our) last engagement survey, the two lowest scored items were related to senior leadership.

Keisha, who has two years' experience as a nurse manager (tertiary hospital, intensive care unit), agrees that senior leaders need to have more presence on the units:

> They could round through the units a little bit more. I mean, I get they have a lot of stuff to do. That stuff has to get done. But, you know, maybe once every month somebody could walk through the units and say, "Hi, I'm the COO or CNO. I'm just doing some rounds." Our CEO and CNO do town halls … but they could do leader rounding. They could round with the staff more, explaining why (things) are important to them instead of just having the nurse managers do it. Because I feel like people see me come in sometimes and they're like, "oh, there she is again."

Holly echoes these sentiments:

> I think the understanding as far as what is truly going on outside of administrative offices is important. That's why I think it's very important for leaders to engage with the staff—to have a true understanding of what frontline staff members are going through.

Xena, a recent nurse manager who is now a nursing director (community hospital, medical-surgical unit), shares that the CNO is present on units at her organization, primarily via periodic coffee hours:

> We're on the unit with coffee and snacks, and it's just an opportunity for the staff to talk. Now mostly it's been about compensation, and they want more time off, and retention things. But they will bring up staff concerns as well.

Olivia emphasizes that senior leaders could do a better job of walking in staff's shoes, provided they show up on units to gain greater understanding of frontline challenges instead of micromanaging:

> When it did happen, he came in and noticed one of the chairs is ripped (and said), "Why is it ripped and why haven't you replaced it?" I'm like, you know what, I'd rather you not come.

### *Comparing Notes*

Although most nurse managers interviewed agreed that greater visibility of senior leaders would be desirable, they shared that unit members try to confer as much as they can with each other to address a variety of issues, including those pertaining to patient experience.

For instance, they emphasized the value of shared governance—where select frontline nurses and nurse leaders work together to develop solutions. Often, these solutions are centered around process or quality issues, though patient experience is also considered. According to Keisha:

> We really try to get shared governance involved on decision-making through our unit. So they just finished a big project of redoing our supply room. So now they're going to look at some quality things and how they can tie quality into patient experience.

Nurse managers also feel that it is important to avoid working in silos within their own units instead of collaboratively with other units. They emphasized the value of conferring with their counterparts on other units to "compare notes" of sorts—as where

one unit might be struggling with a specific patient experience metric, another may be thriving. Holly says that her unit had just recently started to do that:

> It was difficult before, when we wouldn't sit down, and it would be like some other unit would have a really good idea and nobody else would know that they were doing it. So it was like, well how are you at a hundred percent and we're all down in the seventies? What are you doing? And it was like, "Oh, I'm doing this." But we didn't have that open communication piece until about a year and a half ago.…See what your co-workers are doing—the ones who are doing very well in patient experience. What can you utilize to adopt or adapt to your own unit? Sometimes you can use other implementations and maybe tweak them to your patient population, and to your staff members as well.

Many ideas and much brainstorming are often generated via unit-based councils, groups where unit leaders representing several units meet to discuss potential solutions to a multitude of issues, including patient experience. Navaeh speaks to the advantage of relying on unit-based councils:

> If one unit's struggling with that issue, the other units are probably struggling too. And so we're able to help address problems more efficiently than ever before.…I'll kind of see what's working, and then we will present some ideas to unit-based council. The unit-based council reps all meet monthly in an acute care council, so they get to kind of converse with each other on ideas that are working on their unit. Like the other day, one of them came back to me after their meeting and she was like, "one of the units had an Easter egg hunt on the unit—can we do an Easter egg hunt?" I'm like, "go for it." So they bounce ideas off of each other in that council, which is really nice.

Nurse managers indicate that the very nature of presence—by nurse managers as well as C-suite organizational leaders—is essential; presence in of itself sends the message to frontline staff that nurse managers and senior leaders at least try to relate to many of the challenges that frontline staff experience. Presence serves to validate organizational messages pertaining to patient experience. Such messages are most often distributed via formal communication channels.

**Formal Communication Channels**

Nurse managers reported that communication about patient experience scores is rendered via several formal channels. Scores are typically posted on huddle boards (white boards usually located near the nurses' stations that typically include information about the current unit patient census, quality issues and patient experience areas of emphasis), as well as via scorecards in staff lounges. And typically, nurse managers communicate with their staff about scores via daily shift huddles (daily check-ins that typically occur prior to the start of shift), periodic (usually monthly) staff meetings, and emails. Huddles, in particular, are useful for constant repetition of the message that emphasizes the importance of patient experience best practices. Sandy asserts that constant formal communication helps to sustain the scores:

> We've been talking to staff over and over in huddles. Like we didn't want to talk about something and stop talking. We realized that sustainability didn't work that way. We had to continue to talk to staff, because the moment you stop talking about something, that's when they go back to the old way of doing things. So we continued to just discuss over and over as if it was a normal conversation—a normal day-to-day thing. And I think that eventually it started to kind of change their way of thinking and change the practice at the bedside.

Ming also went into detail about how she communicates formally with her staff about patient experience scores:

> We have shift huddles three times a day. We share at least one positive and one negative patient comment, as well as our score. If we have a major update, it's communicated in our weekly updates that we send out every Friday—where we stand with our scores, as well as the highlight for (the past) two weeks. It's also communicated at our staff meetings monthly, where we go over our patient experience scores and we have any new action items to request of them (or say) hey, what are ways you think we can improve because we took a dip. When it gets sent to us, we get kind of our raw score, our percentile rank and where we were last year—kind of your positive or negative, like if you were up or down or stayed the same. And then it give you your common

> themes….So we can see what areas are constant themes (and) if they've changed.

Nurse managers often discuss such themes in collaboration with their hospitals' patient experience departments, which have become more prevalent as priorities become more focused on earning optimal scores. Navaeh describes how she works with the patient experience professional that is assigned to her unit:

> We really do a deep dive into our data. I just had a meeting with him two weeks ago, and we looked at our key drivers (those areas that are deemed to have the most impact on the overall hospital rating). … We narrow those down to our top three areas of focus that we want to improve on.

If anything, a few nurse managers indicated that although patient experience professionals helped them to analyze data and formulate action plans, more visibility on the units, specifically in the form of rounding, would be helpful. Keisha admits:

> I wish our patient experience department would round more on the unit. I wish they could do some of the rounding with the patients and then give us that direct feedback. I think that would be very helpful.

Often, to supplement the support provided by their patient experience departments, nurse managers take it upon themselves to review their patient experience scores online through the websites of the survey vendors that hospitals contract with to administer the patient experience surveys. Although a few indicated that there was a learning curve in trying to analyze survey results online, others appreciated the ability to access the data online so they can more closely monitor it and determine areas of concern. Latosha explains:

> We have access to (the results) ourselves. The (vendor) website is very good. It shows you if you have an area that you're concerned about and how you can flesh these things out.

Having access to scores through online resources, as well as through reports that are automatically generated by survey vendors and sent via email directly to nurse managers, is helpful when nurse managers have to defend the scores to their direct reports or even higher senior managers. Although most of the nurse managers interviewed indicated they were relatively comfortable discussing scores with their direct reports and senior leaders, they also described the communication channels with these leaders to be largely top-down. Olivia expressed this sentiment:

> Our CEO comes up and does our monthly meeting, and he's ecstatic over the scores. And God forbid they start dropping, because then it will be very bad.

Wynonna describes this top-down approach at her organization:

> Our CNO does attend (meetings) on occasion, but not every single meeting. But as far as from our CNO, I think it's a trickle-down effect from our boss. … I kind of have to hold accountability for my areas to my boss and, you know, my boss has to do it to her boss, and so on and so forth. So I think it's trickle-down. I don't think it's the C-suite level coming down asking me about my patient experience scores, but it's definitely coming down the line.

Ming expressed a desire for senior leadership to exhibit a more collaborative communication approach, rather than just issuing directives down the line:

> Like, we know that our scores aren't great. But maybe instead of pointing it out, (they could) ask us, "Well, what do you think is the cause of what can we do to help?" versus just telling me they're (the scores) terrible and I need to come up with stuff. Like, a collaborative effort if you will. Like, "Hey, I noticed your scores have dipped these past two weeks. What are some themes you're seeing on your patient experience? Do you need us to help round? Is there something else we can do?" You know, help (us) or whatever versus say "Your scores are down, and I need you to come up with 6 action items on how you're going to correct it by, you know, the next two weeks."

If anything, nurse managers say that the senior leaders could be more effective at helping them communicate to their staff—not so much issuing directives of what needs to be done but explaining the "why" behind doing it.

**Communicating the Why**

Many nurse managers asserted that although their staff may hear directives that come down the line, staff could really be more versed in the "why" behind those directives (including how reimbursements are related to the scores), because that is something that is not always communicated well to staff. Nurse managers feel that better comprehension of the "why" should start with senior leaders communicating this message, as the nurse managers themselves are more like the conduit passing on the messages. Quinn likened it to a child's game:

> It's kind of like playing that game of telephone. I mean, frontline staff should be more involved in some upper-level things so that they can better see the broader spectrum.

Riley agrees that there is value in staff hearing messages directly from the top:

> There's a process for communicating things up the chain and getting that information back. Whether it's quarterly meetings or forums with the CEO. I always thought that was a nice thing, because it gave people a chance to ask difficult questions and get answers. Where they're not just hearing it from me, but they're hearing the same message, or maybe a different message, from the leadership of the hospital. I think having opportunities to have face time with them, I thought in places I've worked that did that (it) meant a lot to the staff. They felt heard. They felt seen. They felt important.

Deirdre agrees that senior leaders should be more transparent with staff about why patient experience scores are so important:

> I guess I feel like senior leadership, at a lot of places, doesn't give that information to staff. I don't know if they don't feel like they think it would be relevant to them, or if they feel like they wouldn't understand it. It's, you know, kind of a condescension thing.

For their part, nurse managers realize there is often a disconnect in facilitating better understanding of patient experience scores among their staff—from understanding the questions to also understanding the stakes. As such, they actively strive to help staff comprehend the scores. Wynonna explains:

> One of my big things when I became a nurse manager was to really get the staff to understand what questions are being asked and what it all means, because I don't think a lot of nurses, like staff nurses at the bedside, really realize what patient experience scores are and what HCAHPS scores are, and what they mean. So a lot of work that I had done in my management years was around really educating the staff. That included sharing with them what the questions are and how they're asked. You know, the whole process really. And so that really, I felt like gave them a better understanding why we were doing the things we were doing.

Often, nurse managers explain the "why" to their staff—and respond to potential pushback—by putting it into terms of dollars and cents. According to Sandy:

> When the surveys came out, a lot of the nurses (had) never heard of that. It was never a thing. I think they were just all like, well what is this? What's this new information? Like, we've been doing this, it's been working for so long, so why do we have to change the way we approach patients?…It's a business aspect, how we get reimbursed…a letter grade for our organization so we can continue to get the patients and get the funds, and everyone keeps their jobs. We can get equipment, we can get all these new and nice and shiny things. Once I started to explain it to them like that, they were like, oh, we do need more equipment. I'm like, yeah, so that's kind of how we do things so we can get these funds, because it's different now.

Nurse managers felt that although explaining the financial ties was the most practical way to convey the "why," the core of "why" has to come from deep within. Quinn succinctly stressed this point:

> I believe that when you do help people develop certain aspects patient experience wise, yes, you can have regimented expectations and policies. And still, if a person doesn't have a compassionate heart or empathy, you're only really going to get so far with those scores.

Nurse managers agreed that the largest influencer of patient experience perceptions by patients lies in the personal connections that their staff can make with patients. This is a point that nurse managers are constantly emphasizing with staff—and that a big part of connecting depends on the degree to which they listen to their patients. This starts when staff figuratively put themselves in their patients' shoes—perhaps by imagining that patients were their own family members. Ursula generalizes this sentiment:

> Just because we're able to meet their health needs doesn't mean that we have successfully treated the patient. Because a lot of times we find that the patient has so much more going on than just the health concerns…. They can't focus on what's in front of them and their health concerns.…You know, it's well, I can't pay this bill, or I'm going to get evicted.…So there's so many scenarios.

Olivia often reminds staff to acknowledge how patients may be feeling, and stresses when patients are grumpy listening can make a difference:

> I just remind them (to) please put yourselves in those shoes. You know, when you're having an IV machine beeping in your ear, it irks me and I hear it in my office. Now, just think you have an IV machine beeping and it's right in your ear. You're not going to be very happy…(Staff) take everything personally, and it's like they're not griping because of you. They're just sick. Listen to them—that's all. Let them tell you what happened and then say I'm so sorry.

Much of the time staff do feel like they do listen to patients, but often, particularly when care is not narrated (where nurses explain to their patients what they are doing), patients' perceptions are the opposite. For example, some of this may be attributed to technology, where staff may chart patient information on a computer or look up information on their cell phones, only for patients to feel ignored. According to Keisha:

> One of my (patient) comments was staff seem to be on their cell phones. So I posted that for everybody and said this is what people are

> seeing. Like yes, you may be looking up a med, but they're not seeing that. They just see you on your cell phone.

Although there are practical components to communicating the "why," such as ties to reimbursement, nurse managers expressed that it involves so much more than dollars. According to Deirdre:

> I guess I'm very pragmatic. I mean, no margin no mission. (Though) if we can't provide good care that makes the patient feel respected and heard and cared for, then what are we doing? I feel like if we can put it into those terms, almost everyone can understand and appreciate that.

Still, most nurse managers conveyed that helping patients understand the quality of the care they are receiving often necessitates figuratively "teaching to the test." That is, employing the use of key words and phrases to reinforce verbiage that patients could subsequently see on the patient experience surveys.

**Sticking to the Script**

Research has shown that increased response rates lead to higher scores (Godden et al., 2019). Nurse managers shared that one of the first challenges to earning optimal scores was to boost their response rates by increasing patients' understanding of the survey's existence. Because rules imposed by the government forbid asking patients for positive ratings (Press Ganey, 2014), communicating about the survey can be a delicate process. Nurse managers say they instruct staff to simply inform patients that they may receive a survey via a phone call, email or traditional mail, and that their feedback would be appreciated. Olivia explained the framing of this and how she herself communicates this to patients:

> A lot of times, when they're telling me everything is so wonderful and how everybody has been so helpful, I've gotten very used to saying, "I'm asking a great big favor from you when you get home. After about 10 days, once you're discharged, you will be receiving a survey

> regarding the service that was provided to you here on this unit—all of the care given to you here. And we would greatly appreciate it if you send it back. That's how we get graded." Because it's true. That's how we get graded.

Additionally, patients are unfamiliar with many of the terms that are referenced on patient experience surveys. As such, nurse managers train their staff to use the specific terms to trigger patient recollections when they complete the survey. Studer (2008) refers to such scripting as "key words at key times." Keisha explains:

> I want to make sure when somebody's asked a question, sometimes if they don't hear the same word in it, they may not know what somebody's doing.…It's just trying to get staff to use that verbiage…because if you ask somebody a question two different ways, you're gonna get two different answers.…Make sure you're using those key phrases. So every time somebody goes into the room, they are expected to say, "Hey, I'm here to give you this medication. Here's what it is. I'm also doing my hourly rounding."

Wynonna explained that the use of trigger words is a doable strategy—one thing about the survey results that are within their control:

> (It's) really focusing on things we can do. That's when we really drilled down on the buzz phrases; educating the nurses on the questions and reframing how we were doing things. So the staff are constantly saying "we're doing our hourly rounding." And I said, "well, are you telling the patients?" So really, you know, we have to narrate our care. Working on that narration helped guide us in the right direction.…We made a buddy badge (a card that fits behind staff's employee badges), just as a reminder of some of the things to say. You know, I'm your nurse on day shift today, we are going to do our bedside shift report. Explaining that you're doing that report and we're including you in our care. Even just saying the plan for the day and explaining—hey, you have a test today. But the patient doesn't recognize that was their plan for the day.…And they would say no one told me. So (it's) really narrating your care to use those phrases, so that the patient understands exactly what we're talking about.

Nurse managers expressed that they ask staff to be deliberate in how they communicate to patients, not only through the use of key words, but also in the way they

communicate their own workplace challenges. For instance, staffing (or lack thereof) often comes to the surface. Staff often want to explain to patients the delays in responsiveness due to being short-staffed, but nurse managers strongly discourage that. Wynonna asserts:

> Patients shouldn't know that we are short-staffed. We are still responsible to take care of them. That's when they come to our hospital and choose our hospital. They're expecting them to still provide them with the same care. And some staff kind of resist (and say) "what do you want us to do?" And I said, "imagine you were in the hospital and heard that everyone's short-staffed, and your mom was really sick. And you're at the bedside thinking to yourself who's taking care of my mom?" That's why even if you are short-staffed, it's how we're framing it to the patient. Instead of saying we're so short-staffed today, (say) "I'll be right back with your pain medication in 20 minutes—I have to go help another patient, but I'll be right back." It sounds a whole lot better. And the patient's perception is that you still care for them, and they can still trust you.

Although nurse managers agreed that it was important to coach staff on how to frame their words in a way that will influence patient responses on patient experience surveys, they will at times get pushback from staff about how doing so makes them sound highly scripted or prescribed. Overall, this might be a slight grumble. However, this irritation, coupled with nurse manager diligence to hardwire best practices (e.g., hourly rounding on patients, bedside shift report, etc.) and continually talk about the patient experience scores, can adversely impact staff morale. As such, nurse managers practice specific communication strategies that will preserve staff morale.

**Preserving Staff Morale**

Nurse managers, by and large, emphasized the importance maintaining positive spirits among their staff. Pertaining to patient experience scores, they often expressed that they filter messages that come down the line from senior leaders to not adversely impact

morale on their units. Evie contends framing the messages that come from the top toward staff is equally important:

> I feel like I'm the buffer. I feel like it's my responsibility. Like, a dam breaks and I'm the levy. I feel like it's my responsibility to soften that blow to the staff. That doesn't mean I don't hold them accountable.… It's just now I say things to them rather than, "You're doing this wrong—do better." It's "Hey, what can we do to work on this together?"

Ming also admits that a degree of sugarcoating is necessary when communicating to staff about patient experience scores, even if the buffering counters the measures used in the HCAHPS (e.g., always, usually, sometimes, never, etc.):

> When we're not doing well, I shield a little bit in terms of "well, they need to do this." I try to get away from absolutes—we "always" or we "never." Because I don't think you can say that in healthcare for some things. … I think I'm probably a protector of how the messages are delivered. Because while I can handle straight direct feedback, not all of my people can and (we) need, you know, a softer approach with some of that. Sometimes I'm too direct. So I need one of my other leaders to add a little fluff to the messaging. So I think some it's just the way it's delivered—more the shielding.

Another communication strategy that nurse managers use to "soften the blow" is constant positive reinforcement—even if patient experience scores are not aligning with goals. Olivia explains how she frames this communication:

> You know, it would be, you guys, you're doing so well. You're doing such good things. I see how hard you are working. And yet we're getting these scores. What can we do to improve them? And so it was very stressful to think that all of the good things that we are doing to keep our patients safe and providing high quality care are overshadowed by what (patients are) perceiving.

Cora, who has seven years' experience as a nurse manager (tertiary hospital, medical-surgical unit), concurs that lifting spirits among staff is crucial, and sometimes that entails just letting go of the scores for a while:

> On hard months, hard days, the atmosphere is heavy. Patient acuity is heavy, and staffing is an issue. And if that that month had a lower score, I will not bring it up to say we had a bad score this month. Just because I know everything that is going on. This is not the right time to bring up a score.

Most of the nurse managers interviewed asserted that acting as a buffer between senior leadership and staff is crucial. Ultimately, they agreed, tending to staff morale will ultimately result in optimal scores. According to Deirdre:

> I kind of insulate (staff) from the expectations and demands of senior leadership. I gave them the information because I thought it was important. I guess my leadership style is that I feel like if I do a good job taking care of the staff and getting them what they need, then they will in turn do a good job taking care of the patients, and then the scores will take care of themselves. That's part of my job—to be the gatekeeper between the staff and senior leadership.

Additionally, nurse managers overwhelmingly expressed that they consider themselves allies with their staff, and if forced to choose sides they would prioritize the needs of staff over the directives of senior leaders, as they recognize that numbers on a survey do not always represent the efforts by staff. Still, nurse managers' thought that by building trust and rapport with staff, patients' experiences will take care of themselves. Ursula is adamant about this point:

> I cannot stress that enough. It's not like I don't care about my patient experience. I do. But if I have happy staff, and they work together well, and they know that I'm here to support them, they will listen to what I have to say when I talk about (making) these improvements on our patient experience…Build that relationship with your staff and the rest will fall in place.

Evie feels much of her purpose as a nurse manager is to figuratively take the temperature of the team to ensure staff satisfaction:

> I feel like my purpose and the reason I became a manager was to take care of the people who take care of the patients. And so, for me, it causes almost a moral dilemma to go hammer somebody with, "You

> need to do this and you need to do that" to improve our scores, when I feel like I need to be showing them the grace that we're expecting them to show the patient.

Gloria has six years' experience as a nurse manager (tertiary hospital, float pool). Although she is not directly accountable for patient experience scores, she knows that the float nurses and traveling nurses she manages can significantly influence a unit's patient experience scores. At times, others may blame those she manages for less than stellar scores. But for her part, she is not conflicted about choosing sides:

> I've always been somebody who sided with the staff. I've been told that's a weakness—that I need to not necessarily fight as hard as I do for them at times. I don't see it as a weakness. My old director called me Foghorn Leghorn and I was like, "what do you mean?" She was like, "you're always saying well, this is what they need." But that's my job. My job is to advocate for them so they can have what they need to be able to take care of the patients. Ultimately, I'm not caring for the patients; I'm caring for them so they can care for the patients. It's a challenging job, to say the least.

Nurse managers agreed that a big part of tending to staff was to make sure they were constantly recognizing those working "in the trenches" to care for patients. Wynonna asserts that such recognition is beneficial for everyone:

> I try to recognize my staff as much as possible, and I really track my recognition as well, to make sure that I am providing feedback to all staff members equally. I think that's really important. It's also pointing out what's working well, and what is really great for our patients.

Quinn agrees that honing a positive environment is essential for boosting patient experience:

> It makes it a whole heck of a lot easier to get a message across when you're trying to be inspirational and help people see the impact. You know, we would (read) patient comments, read out loud nominations for (employee recognition) awards, encourage people to recognize their co-workers (who did) something loving or caring for a patient that helped their patient experience. We gave them the platform to be able to talk about the things that they did not feel were supporting the

> patient experience. So that really helped.…It isn't just about the scores, you know. Helping the team come up with the processes, helping to change that cultural mindset in people—it's a lot more dynamic than just really flipping a score.

Although nurse managers agreed that senior leaders were focused more on numbers, they found patients' positive verbatim comments on the surveys to be most helpful and a great source to draw from to recognize staff. Xena explains how she uses patient comments:

> We focused on the comments. We would have positive comments displayed on the unit. We had done some things with our unit council where we put a drawing in one month with all the positive comments and whoever was mentioned in that positive comment.

Adele also uses positive patient comments to boost staff morale:

> I like printing out the comments. I like them being up on the board for people to read. Just because I really do feel like that's where you're like, "Alright, we are doing a really good job." It doesn't always come down to the numbers.

For her part, Tessa tells staff to focus not so much on overall numbers but to work toward providing a "starfish experience" for patients. The tale of the starfish is about a boy on a beach who picks up one starfish, among thousands, and throws it back into the sea. The point of the story is although it may be impossible to save them all, at least it is possible to make a difference for a single one—and that in itself is powerful.

In addressing RQ2, which explores the relationships between patient experience scores and communication, nurse managers' testimonies show evidence that organizational expectations to meet patient experience goals influence nurse manager communication behaviors. Although communication about patient experience largely takes place via formal channels (e.g., daily huddles, staff meetings, etc.), nurse managers indicated that truly gaining buy-in from staff about patient experience entails a more

comprehensive approach to communication. Mere visibility on nursing units by both nurse managers and senior leaders sends the unspoken message to staff that they are willing to walk along with staff in their shoes. Additionally, deliberate efforts to round on staff (as a way to more or less take the temperature of the unit) and preserve staff morale may help to inform strategies that will help nurse managers meet organizational patient experience goals.

Enhanced communication—both formal and informal—among organizational structures could also be instrumental in stemming conflict that nurse manages experience in relation to patient experience scores. The next section will explore the relationship between patient experience scores and nurse managers' experiences of conflict.

## RQ3: Patient Experience Scores and Conflict

The final research question of this study explored how nurse manager accountability for patient experience scores influenced nurse manager perceptions of conflict within their organizations. Themes that emerged from the interviews focused on staffing shortages; minimal shared accountability; unrealistic patient expectations; lack of voice; and lack of holistic perspective.

### The Staffing Saga

By and large, nurse managers are frustrated about a constant lack of staffing within their organizations and how not having enough people to staff the shifts—whether it be due to not enough people to begin with or staff turnover—adversely impacts patients' experiences. Perhaps this is due to overall nursing shortages, coupled with the loss of part of the nursing workforce due to the COVID pandemic. Still, some nurse managers feel that senior leaders tend to do as much as they can with the fewest resources

and do not give staffing issues the attention they warrant. Riley contends that she does the best she can with what she has, but being understaffed ultimately affects care:

> It's like there's no crying in baseball. Well, there's no excuses in nursing.…We can't say…we didn't have enough help last night. Like we can't—that's not a thing. You have to get the same amount of work done no matter how many people you have. And we have people's lives in our hands. So that attention to the HCAHPS scores and that pressure on us.…I always felt like you should never use staffing as an excuse to give lousy care. However, there are so many, so much missed care when you're working short.

Patricia, a veteran nurse with approximately 16 years' experience as a nurse manager (tertiary hospital, pediatric unit), voices her own exasperation about staffing issues:

> I guess at times, like, there's such a big push that we have to, you know, get these scores. But then you're realizing okay, we've got to get these scores, but we're working like 10 nurses short this shift. What are you expecting?

Nurse managers convey that they also have to deal with staff who are equally frustrated, so patient experience can sometimes be a hard sell. Holly contends that staffing is an issue, though it could be a component of a more overarching situation:

> Sometimes staff, they feel like no matter what we do, we're never doing everything that leadership says we should be doing or that they want us to do. You know, don't they understand that we're short-staffed? To me, that's not always the issue, because we've been short-staffed for a long time.

Navaeh agrees that staff themselves frequently raise the issue of staffing, but as a nurse manager she can't always offer quick solutions:

> You know, they'll just keep going back to staffing. They'll keep coming up with the reasons why they're tired, they're burnt out.…Sometimes I let them vent, if it's the right setting. I say, yeah. You know, you're right.…(But) sometimes the time just doesn't allow that when you have five patients. Sometimes you're picking up six on night shift. And the things you want to do, you can't do. But if your

> patient's happy and you did everything that you could do for them and the things that were required for their care, then you have to be okay with that sometimes.…What the staff needs is not what we can give them right now. And so sometimes it's hard to feel like we're living up to the expectations that we have on our unit and of our scores, and what we want to be as an organization.…It's hard to do with the challenges we're facing.

Although nurse managers cited staffing as one of their largest stressors, both in general and in working toward optimal scores, they also opined that accountability is placed solely on them and their units, when ideally the credit or the blame should be shared by others within their hospitals.

**The Blame Game**

Nurse managers pointed out that patient ratings are assessed only to the discharging nursing unit, and as such the sole accountability for patient experience scores rests on them. Yet, they assert that the entirety of patients' experiences is contingent on every encounter, no matter how large or how small. This means that other units, departments, nurses or physicians within the hospital could have just as much, if not more, influence on patient experience scores.

Several nurse managers said that patient perspectives of their care—including the overall assessment of the hospital they are in—could rely on factors beyond nursing. According to Cora:

> Every department in a hospital has to be working—functioning efficiently for these scores to go up. It cannot just be one person, the nurse trying to fix everything in order to increase scores. There's a lot of times where I felt powerless, and the staff sees it. They know, but then I'm supposed to continue to work on these scores with them. I can't tell them, "Well, it's not us. It's everyone around us that's taking these scores down."… I have to continue on with new projects and new initiatives to see how we can help increase the score. (Yet) a lot of it has nothing to do with nursing.…We could do the best we can. That might help a little bit. But if the food's not great, the environment's not

> good and there are delays in testing, nurses could do everything they can but that will impact the score.

Many nurse managers stressed how important ancillary departments are to patient experience. In fact, Riley feels that ancillary department personnel spend more one-on-one time with patients than does nursing, and that everyone—from the registrar to the housecleaning staff, impact patient experience:

> So much pressure is put on nursing—when you know if one person's mean to you, you're going to give me a six.…It's not just the nurses. Like your ancillary people are key people too. That might have been the phlebotomist, but it's still a reflection of the care on my unit, and I'm accountable for those scores.

Nurse managers also pointed out that patient perspectives of their care may originate in the emergency department, which serves as the initial view of the hospital. Approximately 70% of inpatient admissions originate in the emergency department (Augustine, 2019), and if that original encounter causes sour feelings, patients can carry their feelings over into the inpatient stay—even if the patients felt they had the best inpatient care possible. This is particularly true when patients spend an extended amount of time in the emergency department, due to no inpatient beds being available. Sandy explains the struggle of altering patient perspectives after a bad experience in the emergency department:

> It would be a challenge to try to keep up or try to change the patient's mindset or their satisfaction.…So it was just trying to turn and change a narrative once the patients got to the floor.

Ursula echoed sentiments that a bad first impression can skew scores for everyone:

> They can tell me one thing but put something totally different on the piece of paper. They may have had a bad experience in the emergency room or the operating room, but because they were discharged from my

> unit, it hits me. So that gives me stress. I don't feel like (patient experience measures) always capture everything.

Beyond other units, ancillary departments, or the emergency department, nurse managers said that another factor within their own units could influence negative scores: nurses on a unit when it's not their base for work. This could include other staff who are "pulled" to a unit other than their own due to staff shortages; float nurses who fill in as needed on units; and travel nurses from outside agencies who are hired by the hospital. The latter two, in particular, may be subject to some animosity by a unit's staff nurses, because they are paid more—despite a possible lack of buy-in to the culture of the unit. Joanna expounds on this and suggests a possible solution:

> Sometimes we have travelers on the units and float pool nurses who, I believe from my experience, their focus is not on patient experience. Their focus is on doing their job and leaving, because this is one-time. They're not here every day.…Patient experience is not something important to them. So if we can put more effort into educating these nurses or following up with the nurses, it would have a great impact. I have escalated multiple times a complaint because of a float pool nurse, and I didn't get follow-up (or whether) something changed. So if upper leadership would really put an action plan into how to train travelers and float pool nurses—how to include patient experience the same way it's included for regular RNs—that would really make a difference.

Finally, a few nurse managers indicated that physicians greatly influence how patients may assess their experience, either due to lack of communication with nurses, or lack of communication with the patients themselves. Fiona expresses this frustration:

> Our scores are rocking in terms of nursing. But maybe they (patients) had a provider who didn't listen, and that's kind of where all the stuff goes. Of course, I don't control the doctors—as much as they say I try to control everything. There's a consistent doctor that I keep raising up that's a concern—he's still here. If it was my nursing team, we would not get nearly the grace that the providers do.

All in all, the lack of shared accountability for patient experience scores, which in turn results in nurse managers getting the blame when scores are not at the organization's goals, poses a point of conflict between nurse managers and those who lead the organization. Nurse managers also feel that proper credence to patients' unrealistic expectations and lack of ownership of their own health is not accounted for when scores are calculated—which is a frustration for both them and their staffs.

**Health versus Hospitality**

Nurse managers conveyed that many patients expect certain perks when they are in the hospital, making for a setting where patient expectations are often unrealistic. The consensus was that it is not enough to effectively treat patients' ailments; instead, the scores are contingent on additional perks that patients expect. Thus, nurse managers are often disillusioned with the dilemma of focusing more on hospitality, particularly when giving patients what they want would not be in their best interest. This situation can pose conflict within the organization, especially when senior leaders place such emphasis on only the numbers. According to Tessa:

> I feel like the hospital has moved into the hospitality industry. You want to have the best experience, but I think some of these expectations are just unrealistic. I don't think we fully grasp what their expectations are. You know, we're a place of healing. It's not like you're going to get a Hilton five-star resort.

Ursula voices her own exasperation about unrealistic patient expectations:

> It doesn't matter what you do. You feel like you can't please them. I've given you everything (but) the kitchen sink. We have just oozed kindness, and still (they're) unappreciative. So it's like, okay, are they filling out the survey because, you know. Like we have done everything, done back flips, for you, and you're still just very unhappy. And it's like, I don't know what to do to make you happy.

Nurse managers cited several reasons why they have little control to meet patient expectations. Patients in semi-private rooms, particularly when they are mismatched with a roommate, may be one source of discontent. Other reasons—such as those pertaining to the quality of the food, room temperature, or the size or age of the room and its furnishings—may seem more frivolous in nature but hold just as much weight in influencing patients' ratings. Riley opines:

> The temperature of your food—how is that relevant to your healthcare? Like if it's a hotel, I get it and we don't want to give you cold food, but is that what you want (as the) focus? If they are going to answer you (via the surveys) and you're going to give weight to that (survey), don't you want to just ask the most important things? I'm not saying it's not important. I'm just saying I don't know that your Medicare dollars should be tied to that.

Evie feels that patient experience measures should be tied more to outcomes rather than hospitality issues and that at times trying to accommodate what the patient wants is not necessarily what is best for the patient:

> You have a diabetic that's on an insulin drip that that wants three ice creams with dinner, and you're like this is not good for you. Or you have a cardiac heart failure patient that's like give me the salt shaker. This is not good for you. People are all about their food. As soon as you withhold that, (patients say) "you people are the worst." (And nurses sarcastically say to themselves) "yes, this is the worst hospital ever." And so it's very hard.…Making patients happy seems to be the drive rather than making patients well.

At times nurse managers must choose between receiving an optimal score and the best interest of the patient. Keisha explains:

> I will take a lower patient experience score if I know that we're doing the right thing for the patient. We do try to just explain it to them as best we can. Like, we can't give you pain medicine because you have to be able to get up and walk today or you're going to get pneumonia—things like that.

Thus, nurse managers agree that although not meeting patients' hospitality expectations might result in lower scores, it is worth that sacrifice, as long as they can keep patients safe and make them better than when they arrived.

The path to wellness, however, is not always easy, particularly if patients do not take ownership of their own health. Evie illustrates this point:

> I think there needs to be some questions that gauge patients' personal responsibility and accountability.…If I'm trying to teach you about medication and you're telling me I don't need to know that because I understand, but you don't, really. And then you go and (answer) the survey question, "No, they never talked to me about that," because you weren't listening when we were presenting the information. Or you weren't engaged in learning about how to take care of yourself at home. There's some disconnect there.

From a communication standpoint, many nurse managers agreed coaching staff to communicate realistic expectations to patients may be an opportunity for improvement. According to Ming:

> There are some very unrealistic expectations on what you'd get in a hospital versus a hotel. So I think maybe even a level set of, "these are the standards you can always get when you're with us. We will answer your call bell within X number of times, we will do X by this time." I think kind of standardizing what we're really looking for in patient experience would be good.

In particular, nurse managers agree that they and staff should prioritize the setting of patient expectations about pain. Riley explains how dealing with patients' pain can be a touchy subject as it relates to patient experience scores:

> I feel like (we're) leading them to believe they should expect no pain, which is not realistic. When you get a chronic pain patient…that (pain) existed before you came here and it's going to exist long after you leave. It made us way over prescribe pain medication. I mean, doctors were afraid to discontinue it (pain medication) because of the patient experience scores that were tied to their bonus system.

Although more effectively communicating expectations to patients is an area that could be more of a focus, nurse managers revealed that often quality solutions can be found by listening more to ideas posed by frontline staff. Yet senior managers don't often listen to the suggestions coming out of the trenches. Instead, they direct nurse managers to implement one or many "best practice" initiatives to help boost patient experience scores. As a result, with these directives staff often feel like their voices are not heard.

**Do This—Do That**

Nurse managers indicated that senior leaders are open to frontline perspectives, though when problems are brought to the top, senior leaders do not always have the answers. At her organization, Xena feels that staff can openly share their concerns:

> I do think the senior team listens. They do their best, but there's just some things they can't control. I don't think they overtly put too much pressure on things they can't control. They (staff) have no problem emailing the chief nursing officer or texting the president of the hospital. The staff feel very empowered to bring concerns and complaints forward.…The senior leaders are pretty visible as far as identifying opportunities. They'll round on units, tell me how things are going, or if they see a trend, they'll try to address it. I just think some things are hard to address.

Many nurse managers, however, felt that staff suggestions fall on deaf ears with senior leaders, possibly because senior leaders feel they should be responsible for mandating certain solutions to boost scores. Quinn expresses how organizational communication dynamics are often one-sided, particularly pertaining to patient experience scores:

> It's sort of one-sided, like sometimes you don't feel completely heard. It's more like, "Here, here's this. Now do this…you must do it" kind of thing. You know, we are on the front lines, so we probably have really valuable input. I do believe that frontline nurses should be in attendance more at things with the management staff, so that they can really communicate better with senior leadership.

Gloria echoes the sentiment that sometimes one doesn't have to go beyond the unit to find the answers:

> I've sat in meetings where I was told that, or I overheard my peers being told that, our ideas were dumb and that they would never work. There's not that psychological safety even to speak up. If you have leaders who aren't willing to listen to your suggestions or you don't feel safe to say them, it's never going to change or get better. Listen to the nurses. They know how to fix it, even if it sounds crazy. We have permission to fail sometimes, and that's all right. As long as it doesn't hurt our patients. I think they really are the ones who can fix the problem. So if there really is a problem on the unit and you're not seeing the outcomes and something's wrong, spend time with the nurses. They'll know how to fix it. And support them in fixing it.

According to Adele, when staff do not get a chance to weigh in, it can lead to senior leaders directing more work to nurse managers and their frontline staff:

> So you feel like they're just kind of throwing you all these initiatives, and without any thought. I mean, there's great thoughts and I think there's great reasons behind them, but I don't think they always get enough frontline feedback about what they can fit into their day.

Riley can relate to being overwhelmed with too many initiatives to hardwire patient experience best practices. She shares that one of the organizations where she worked hired consultants to train them on the various initiatives:

> But once they left, you know, I felt the organization tried to still follow those tenants that were given, and then things just morphed over time. Some of those things that we were taught were very successful fell by the wayside for a lot of different reasons.…You know, it's like I (was) always thinking of it like juggling where you have nine balls in the air, and you're juggling and they throw you one more, and one of the balls is going to fall.

Once improvement initiatives—such as hourly rounding, bedside shift reporting, or scripting of key words—are launched, senior leaders expect quick results, even before

best practices are effectively hardwired; and if those results are not forthcoming, senior leaders may push another initiative down the line. Holly offers her take on this process:

> We may have the same goal (to boost scores), but then we're looking at different implementations to reach that goal. So if something's not working and you haven't given it time to work, then upper leaders tell you okay, we're going to do this now. So this is a new "flavor of the month." So you have to decide as a leader, how am I going to manage this for myself as far as do I truly believe in this?

One such initiative that affects nurse managers directly is the implementation of mandated nurse manager rounds on patients. By and large, nurse managers expressed that visiting with patients on their units (when they have time) is meaningful. However, their organizations often expect them to complete rounds on a certain percentage of the unit's patients each day, with several hospitals embracing the mantra, "Every patient, every day." Conducting rounds often entails using rounding software via a tablet to ask patients a set list of questions to determine their experiences, and some nurse managers implied that the practice was more about checking boxes rather than having meaningful conversations. Rounding on patients is also time consuming, and nurse managers worried that asking the same questions to the same patients every day would be viewed by patients as more of a disturbance than a friendly visit. Finally, nurse managers were worried that the process of rounding in this way was more scripted and less spontaneous. Riley shared that when she was with her previous organization and worked with patient experience consultants, the expectation was to round on every patient every single day. In her current organization, she only rounds on new admissions, making the process much less prescribed:

> Of course if there's an issue, I'm going to follow up with the patient again the next day.…But I think just making it…less like you have to do this robotic thing, and you have to use this script and say it in this

> word. I had a lot of trouble…especially purposeful rounds. I think people want to put their own spin on it.…There are different ways that you can communicate and not feel robotic and still achieve the same goal.…I wonder if some of those discrepancies in what I was hearing during rounds and what the scores ended up being was that (patients) were just fearful. They think (by giving bad feedback) that there's going to be repercussions—they won't check on me, or they'll take it out on me, or not bring my pain medicine.…So I think there's some fear in there that doesn't always get you a result (when rounding on patients).

Deirdre echoed that information garnered from patients did not seem to always be genuine:

> I didn't feel like I really got information or feedback that I felt was useful or authentic. A lot of times these patients are sleep deprived—exhausted—and really didn't want yet another person coming into their room and asking them a bunch of questions. And so, unless things were really horrible, (the patient response) was always, "Oh yeah, everything was great." And so I felt like it wasn't really an exercise that was very useful. But it was required of us leaders to perform X number of patient rounds per day.

Evie suggested that quality over quantity would make a difference in making rounds on patients more meaningful:

> Rounding takes a long time. What I would like to see is focused rounding instead of every patient every day to check a box. So I go in and I spend 15 minutes with (a few patients) instead of five minutes with every patient every day.…Rather than just hammering them with questions, I try to actually make it a conversation, and that tends to take longer. But I think you get better information. I also find that that when I round in the discharge lounge, these people are like one step out the door and they are a lot more forthcoming with things they didn't see go as well and they would have liked. So I get my most honest feedback from these people.

Wynonna shared that as a nurse manager she finally told her supervisor that she simply did not have the time to see every patient every day:

> It's very hard to do with all the competing priorities. And I said to her, I am somebody who likes quality over quantity. I truly believe in that. And she full on supported me. And I think having that support really

> allowed me to do so. So I was making quality rounds and able to spend time with the patients and really talk to the patients…but maybe not seeing a hundred percent.

Not only are nurse managers expected to conduct daily rounds on patients, but also senior leaders issue directives for staff to implement a myriad of initiatives. These expectations by organizational leaders can also be a source of conflict. According to Evie:

> I have felt conflicted because I do put such emphasis on taking care of my people. I feel like some directives and some push to do more with less is very hard for me to get behind. So senior leadership says we're going to do this initiative and staff's not going to like it. Maybe it causes a different workflow, or maybe it's more time-intensive, and I have to, as the organizational middleman, push that directive onto my staff. That's very hard, sometimes. Sometimes internally I'm like, oh man, how am I going to make it palatable to my staff?

Even more frustrating, says Gloria, is that priorities pertaining to patient experience seem to change day by day:

> We coined this term called the pendulum swing. So there's all these priorities and one day it's this is the priority, and the next day this is the priority, and I know we need to be able to pivot. But if we could just focus on a few things, and let us focus on that…keep some sense of not going to extremes, it would help us out greatly.

For her part, Keisha tries to frame the addition of various initiatives as not working harder, but working smarter:

> From the bedside staff, they're going to be like, well, we're working our butts off. We've done so much (and) you're just putting something else on our plate. So I try to word it as it's not that I'm asking you to do more. I'm asking you to do it differently. You know what I mean? So that's how we try to phrase it and then I try to get their feedback about what they think the patients would want. And then I try to take their responses and build that into our actions plans to meet the needs of senior leadership.

One such widespread initiative is hourly rounding, where staff commit themselves to check in on patients every hour to assess their needs. Theoretically, nurse managers conveyed that hourly rounding is an optimal best practice that helps staff to anticipate patient needs, and when conducted purposefully, it can lead to safer care. Olivia mentions that this is particularly true with bathroom needs:

> If you anticipate what they need—be proactive versus reactive. You know, patients are going to wait until the last minute to ask to go to the restroom, because that's just the way they are. So every time that you're in there (during hourly rounding) try to, you know, nudge them and really encourage to go while I'm here, because I can help you and keep you safe at the same time. The last thing I need is for you to have a fall, and the last thing you need is to have a broken bone.

Still, rounding on the same patients every hour is not as feasible as it sounds, according to Quinn:

> Where did that expectation come from? Did that come from the patients themselves? Did they say I want to see somebody in here every hour? While it does sound realistic, sometimes when you have a patient in one room that is like, unfortunately had surgery and soiled the bed, or if they have a dressing that came off, you know, it's really difficult to get into a patient room every hour.

Another widespread initiative that hospital organizations attempt to hardwire is bedside shift reporting, where staff nurses visit patients during shift change to hand off care to oncoming nurses and consult with patients during the process. This helps to engage patients in their care and give them a voice as they confer with the nurses about their care. Still, certain challenges exist in carrying out effective bedside shift reports, which are only supposed to take a few minutes per patient. Nurses have concerns that the practice takes excessive time; that the practice is difficult to conduct when patients or family members are irritated; that staff often have to wake up patients to do the bedside handoffs; and that patients may expect to discuss sensitive information, such as a

diagnosis that has not yet been communicated to the patient by the physician (AHRQ, n.d.). As a nurse manager, Gloria says that although she supports bedside shift reporting as a practice, the protocol can be more complicated than necessary:

> I am 110% behind it. However, the standard work for it is three pages long and nurses have sometimes up to seven patients. I think the nurses keep saying it, but it's not being heard, is that we really need to look at that standard work and parrot it down—just let our nurses go back to the basics of taking care of our patients.…I think we're focused so much on checking every little box for our standard work and making sure our process observations are perfect, that we're missing the intent of the bedside shift report.

Nurse managers also mentioned other efforts to boost patient experience scores, such as working on making the environment as quiet as possible (not always easy with rolling carts and beeping IV machines), leaving thank you notes for patients, and one particular initiative that Holly says made no sense:

> We were supposed to ring a bell when new patients came onto the unit. So I'm thinking, okay, the units already have enough noise as it is, so you want a bell to be rung when a new patient comes onto the unit? What if nobody sees the patient come onto the unit? Or we're ringing multiple bells, you know, so this can cause confusion, because then there's multiple bells and alarms going off on the unit. So that was a conflict for me.

Nurse managers conveyed that even with the rollout of improvement initiatives, they do not always see changes in the patient experience scores, which can leave staff disillusioned. Quinn indicates that being so focused on carrying out the processes can have unintended consequences:

> Sometimes when you do get laser focused on a score that might be really low…there are other things that the staff get so focused on that they're eager to do. I mean, overall staff are eager to do well. They want to do well. So they're going to feel the pressure to focus on that one thing and, you know, the stress and pressure of that might facilitate them forgetting about something else, even if they didn't intend to.

Adele feels that as the person in the middle, she strives to just keep the peace:

> I just like to try to please both sides, try to keep civility. I feel like the disconnect is kind of becoming larger. (With) the things that upper leadership wants to roll out, they're not looking at what we can kind of take away, and what we can repurpose at a frontline level.

With such an intense focus on carrying out multiple improvement initiatives—both initiatives to enhance quality care and initiatives to improve patient experience scores—several nurses indicated that such a focus on tasks can blur the bigger picture, where patient experience is integrated into the entire fabric of care.

**Patient Experience as Piecemeal**

Many nurse managers expressed that nurses, first and foremost, need to complete the tasks of their job, such as distributing medication, getting their hourly rounds in, and charting patient information into the computer. Because this is a priority, efforts to make personal connections and develop rapport with patients often take a backseat. Adele explains this dilemma:

> Like I don't have time to sit here and talk to this person for 10 or 15 minutes because I'm going to miss my hourly round. We get very task-oriented, and we want to make sure we are checking off everything like we are supposed to. But sometimes that takes away our personality.

With such task orientation, some nurse managers struggle to view patient experience as a holistic concept. In other words, instead of viewing patient experience as one thread woven into the entirety of care, it is instead compartmentalized as separate from the "real" care. As such, some nurse managers worry about other things such as staffing and turnover and view patient experience as its own separate entity. According to Sandy:

> My goal is to make sure my staff are supported and that they have what they need. If I can squeeze some time out to address a patient satisfaction score, I will.

Fiona illustrates the conflict between patient experience goals and the need to tend to both patient and staff needs:

> Certainly, right now, if I demanded as much attention to patient experience, I would have no nurses left. It's a balancing game of how do I meet the team members' needs and how do I meet the patients' needs? Because sometimes those are diversely opposite. I have people who are working overtime and they're tired. I want them to provide safe good care, but if there wasn't a mint on their pillow, I'm still okay with their good safe care. I have to be that buffer to say I'm just thankful everyone is here today. Everybody needs to go home alive.

Inga echoes that patient safety, rather than patient experience, is her utmost priority:

> As a nurse, you know, my priority will always be patient safety. Patient quality (of care) will always be number one. Service will just, service will come later.

For her part, Riley also does not consider patient experience her top concern:

> It's a revolving door with staffing challenges. Like if I went out and told my staff when they have six- or seven-to-one ratios, I would have no credibility if my main concern was patient experience.

A few nurse managers, however, understood the holistic component to patient experience. Quinn points out the importance of integrating patient experience into the entire continuum of care:

> The patient experience to me is like a human experience. The compassion, empathy, and care that goes along with the clinical aspects of your job need to be at the forefront just as much as the clinical aspects of the job. And there are times, unfortunately, you do see in healthcare that doesn't always happen and you can't always help your co-workers, peers, subordinate, whatever. Sometimes it can be quite a challenge.

Ursula emphasizes that that a patient's overall experience must encompass not only the physical components, but emotional components as well:

> Just because we're able to meet their health needs doesn't mean that we have successfully treated the patient. Because a lot of times we find that the patient has so much more going on than just health concerns. Really meeting the needs, all the needs the patient has—mentally, physically, emotionally—helps them achieve or feel that (we) have achieved some sort of plan together.

As this research demonstrates, there is a relationship between patient experience scores and conflict, and that conflict is rampant. Nurse managers try to manage conflict from both sides—with their senior leaders, as well as with their own staff. This serves to exacerbate their own stress and present them with frequent communication challenges. Moreover, this conflict positions patient experience as just another box that needs to be checked, thus impeding nurse managers' capacity to view the concept of patient experience more holistically.

The findings detailed in this chapter support all three research questions that there is indeed a relationship between nurse managers' accountability to meet organizational patient experience goals and their perceptions related to stress, communication, and conflict. The next chapter will outline practical implications of this research, as well as provide recommendations for ameliorating the various challenges. Also, theoretical insights derived from the research will be discussed.

## CHAPER FIVE: DISCUSSION

Research questions posed within this study examined nurse managers' perceptions of patient experience scores and their affiliation with stress, communication, and conflict. Data highlighted in Chapter Four verifies relationships between nurse manager accountability for patient experience scores and stress, communication, and conflict.

First, this qualitative data analysis demonstrates that accountability for patient experience scores is a stressor for most of the nurse managers interviewed, though not as much of a stressor as other administrative functions, such as managing staffing and turnover. Still, a great deal of the stress derives from nurse manager perceptions that they are accountable for metrics that they often cannot control. Although some of this stress is self-imposed due to nurse managers' innate tendencies to be Type A personalities, pressure is also brought on by organizational expectations that patient experience scores continue to increase and sustain themselves—even if the only goal left is total perfection. Stress is also induced because nurse managers realize that they cannot be everywhere at all times, so it is challenging to account for every single thing that may happen on their units.

Second, the data show that nurse manager accountability for patient experience scores can influence the ways the nurse managers communicate within their organizations, particularly to their staff. All the nurse managers described their formal processes for communicating about patient experience scores—such as daily shift huddles, weekly emails and monthly staff meetings. However, many agreed that although they subscribe to an "open door" policy, rounding on their own staff to determine needs

was not a common practice. Nurse managers did express that merely being visible on their units and modeling desired behavior sent powerful nonverbal messages, primarily that they wouldn't ask anything of staff that they themselves would not do. However, they indicated that although they constantly try to convey to staff *why* a focus on patient experience is important, increased visibility by senior leaders and their vocalization of the "why" message would likely carry significant weight. Furthermore, many nurse managers explained that they constantly coach their staff on figuratively "teaching to the test"—that is, using specific key words (within the rules) to trigger patients' memories about their care and subsequently influence their responses to the patient experience surveys. As much as they work with staff, nurse managers also expressed a certain sense of kinship with frontline staff and indicated such allyship means that they ultimately prioritize their staff first over senior leader demands.

Finally, nurse managers shared how their accountability for patient experience scores leads to conflict situations. They are constantly struggling with staffing issues (as well as their own staff's disillusionment with this issue) and feel organizational leadership should prioritize this more than they do. They also are frustrated that they are the only ones accountable for their units' scores, as scores can be influenced by factors other than nursing care—factors related to other departments and units, as well as characteristics of patients themselves when they have unrealistic expectations. Many of the nurse managers indicated that when a slew of improvement initiatives to directly address patient experience come down from the top, it is often overwhelming. Such focus on so many initiatives can be likened to playing "whack-a-mole" and causes them and their frontline staff to be more task-oriented and less likely to view patients' experiences

holistically. Thus, patient experience is compartmentalized and not integrated into the entire continuum of care.

In this chapter I discuss practical implications of the research from macro, meso, and micro-level lenses and offer recommendations for enhancing processes of care—regardless of whether they boost patient experience metrics. I will also assess the theoretical implications of the research and offer suggestions for extending theory. Finally, I will assess limitations of this research and recommend future directions to extend this contribution to the literature.

## Practical Implications

Practical considerations exist as they relate to macro, meso, and micro levels. On the macro level, public policy as put forth by the federal government is due to be examined via efforts to modernize patient experience measures, namely the HCAHPS measure. On the meso level, organizational leaders should re-evaluate how to prioritize patient experience metrics and set goals that nurse managers are obligated to meet. On the micro level, nurse managers may want to consider communication strategies with staff that will ultimately improve patient experience.

### Macro Considerations: Public Policy and Modernizing the Measures

As mentioned previously in this research, patient experience metrics—particularly the HCAHPS—emerged as a result of the federal government's efforts to increase quality and contain costs. As such, the federal government assigns patient experience star scores to hospitals. Patient experience scores also count toward 25% of a hospital's value-based purchasing total score. The value of this score determines how much (or how little) reimbursement a hospital receives, be it through financial incentives for meeting

benchmarks or financial penalties for falling short of benchmarks. Although nurse managers felt that they had some control over parts of the value-based purchasing formula (such as quality outcomes), they felt managing patient experience scores was largely out of their control. Additionally, nurse managers complained that the surveys do not produce timely results and that low response rates to the surveys skew the results. From a policy standpoint, experts have addressed some of these concerns and made several recommendations for modernizing the HCAHPS survey (American Hospital Association, 2019).

### *Digital Platforms: More Timely and Greater Responses*

Improving response rates is essential, as research has shown that low response rates can impede the validity of the survey and lead to lower overall HCAHPS scores (Siddiqui et al., 2014). New ways of distributing the survey may help to increase response rates. Although the surveys have typically been administered via mail and telephone, a new and emerging mode is to administer surveys by email. However, email distribution in itself may have its own challenges, given the tendency for such emails to end up in a patient's spam filter or simply get lost in the stack. The solution to this may be digital distribution of the official survey prior to patients leaving the hospital at discharge (Argarwal et al., 2021). When surveys are provided to patients via tablets on the day of discharge, more people respond—particularly hard-to-reach and minority populations who are typically not represented. Additionally, by digitizing the survey and presenting it on-the-spot, younger, more tech-savvy patients will be more likely to complete it (American Hospital Association, 2019). Additionally, reworking the survey this way will enable a quicker turnaround of results—results that are actually actionable

because of the more timely feedback. (HCAHPS surveys are currently sent to patients between 48 hours and 40 days post-discharge, and nurse managers often do not see those results for several weeks or months after the fact.)

### *Consideration of Health Literacy*

Hospitals whose patient populations tend to be more vulnerable and disadvantaged often received the lowest scores (Evans et al., 2020). These populations may also include patients with low literacy levels. Nurse managers often complained that patient literacy levels are lower than the literacy level at which questions are asked, and as such many patients did not understand certain terms contained within the questions or what the questions were really asking. Concerns about this ambiguity of interpretation have been echoed by others (American Hospital Association, 2019). As such, healthcare policy leaders should reconsider the verbiage contained within the questions and whether they can accommodate lower literacy levels.

### *Credence to the Comments*

Patient narratives that are elicited via open-ended questions add value to the overall survey results (Evans et al., 2020). Nurse managers in this study expressed concern that verbatim comments offered by patients in the survey process often did not align with the actual metrics (comments tended to be more positive than what the numbers reflected) and that organizational leaders prioritized the numbers, only looking at the comments to gain deeper understanding of numbers that were lower than goal. Thus, as they exist now, patient comments are essentially an afterthought of organizational leaders, though nurse managers refer to patient comments often. Policy leaders should consider ways to integrate patient narratives into the scoring mix,

particularly as it relates to overall hospital rating (many hospital organizations base their employees' financial incentives on the overall hospital rating). With advances in technology, this could possibly be achieved in the future with the efficient use of artificial intelligence to initially code narratives, with follow-up evaluation from human coders to validate the context of the narratives. Human coders could then subsequently rate narratives so they can be quantified and integrated into the overall HCAHPS scoring. Of course, employing neutral human coders would entail increased costs. However, integrating human narratives into HCAHPS scoring might help senior leaders gain deeper understanding into the state of patient experience within their organizations.

## Meso Considerations: Organizations Collaborating Across the Board

### *Minimize Loyalty Questions on the Survey*

Nurse managers indicated that one of the limitations of the patient experience surveys was that they were too long. Although the HCAHPS in itself is only 29 questions, most hospital organizations work with their survey vendors to add supplemental, or loyalty, questions that will provide greater insight into patients' experiences. The addition of such questions is allowed by CMS. Unfortunately, this serves to significantly lengthen the survey, often beyond 50 questions. In turn, respondents to these surveys may develop survey fatigue and not answer all the questions to accurately reflect their opinions. Lengthy surveys may also dissuade participation altogether. Thus, hospital leaders should weigh whether collecting so much additional information (through the addition of questions) ultimately impedes the quality of data received.

### *Start with Why*

Nurse managers indicated that senior leaders tend to use a top-down approach to communication to issue directives designed to boost patient experience scores. Such initiatives can take the form of nurse managers rounding on patients, staff hourly rounding, bedside shift reporting, and using the AIDET communication framework. Although nurse managers strive to communicate with their staff about what to do, staff (and often the nurse managers themselves) are unclear about the why behind what is essentially "initiative soup." Nurse managers indicated that it would be helpful for senior leaders to be more present on their units and be clearer in communicating the why behind the actions. Although communicating the why first may seem logical, very few organizations articulate the why behind the what they do. Communicating "what" over "why" is more manipulation than inspiration to motivate people (Sinek, 2011). Sinek (2011) asserts that people in general feel they need to belong, and when organizational leaders share the why (rather than send the message to "do this, do that" down the line), it enhances staff sense of belonging and fortifies trust in the organization's leaders. For patient experience, the "why" should, at the very least, tie back into the hospital's mission. For most hospital organizations that would mean that, in an ideal world, implementation of best practices may serve to boost patient experience scores, which in turn nets financial benefits via reimbursement. This further enables hospitals to provide the resources needed to provide high quality care for patients. Yet the "why" can go further to stress the importance of viewing patients beyond their diagnoses and appreciate them as unique human beings. Wolf (2020), in explaining the need to go beyond *patient* experience to consider *human* experience, says, "This idea, that at healthcare's core we

are fundamentally human beings caring for human beings, is a key starting place for this conversation" (p. 6).

### *Quality over Quantity*

Nurse managers complained that initiatives come down the line from senior leaders so fast that they are overwhelmed and cannot keep up with the pace to hardwire the practices. One nurse manager deemed current new initiatives as "flavor of the month," while another likened the initiatives to the swinging of a pendulum. As such, organizational leaders may do well to be more deliberate on how they mandate initiatives. This may entail working closer with nurse managers to not only be more selective on which best practices to work on but also get a feel of the figurative temperature of the units to assess their own readiness to take on additional challenges. Units with less engagement and lower morale (as demonstrated on employee engagement surveys) may have more difficulty hardwiring new practices.

Furthermore, although nurse managers indicated there was value on rounding on select patients each day, the mandating of quotas or adhering to the mantra of "every patient, every day" is not realistic given nurse manager time constraints and the fact that repeated rounds on the same patients may not net yield insights from day to day. Nurse managers felt that focusing purposeful rounds with a few patients rather than checking boxes with all patients leads to more meaningful encounters.

### *Empathize with Frontline Challenges*

Nurse managers expressed that they would like for senior leaders to be more visible on their units. For instance, shadowing frontline nurses would be an effective way for senior leaders to figuratively walk in the shoes with those involved in direct patient

care. This would be helpful to do prior to formulating action plans to boost patient experience scores, as they can see firsthand the challenges to effectively carrying out mandated best practices. Witnessing these challenges may serve to inform decisions that senior leaders make about managing patient experience. Furthermore, it will give them the opportunity to truly listen to staff who wish to voice both concerns and suggestions for improvement.

### *Teamwork and Shared Accountability*

A frequent complaint among nurse managers is that they are solely accountable for the scores credited to their units, even though much of what influences the score may be out of their control. Thus, they are getting the entire blame for adverse results that may be due to patients' prior experiences in another department or unit, or environmental factors, such as an aging facility. A better system for shared accountability—where all departments rather than just nursing units are accountable for patient experience scores—is warranted. Fostering such an atmosphere of shared accountability should start at the top, with true buy-in from an organization's senior leaders. Although metrics such as patient experience scores are important for providing direction for improvement opportunities, senior leaders should focus more on transforming organizational culture toward an appreciation of human experience. This would include a realization that the staff working under them are also humans. Thus, less of a focus on issuing directives to boost patient experience scores and more of a focus on taking care of staff needs may be considered.

According to Spiegelman and Berrett (2013), healthcare organizations that embrace the concept of putting patients first practice backward thinking. Instead, they

contend, healthcare workers should be the first priority—even over patients—because they are the figurative engine that fuels the organizations. Spiegelman and Berrett target their message toward healthcare leaders by challenging them to take care of employees and instill a sense of pride and satisfaction within them. In turn, patient experience will take care of itself. They assert that part of putting employees first is to hone a culture of collaboration by building solid teams—where everyone works together with the same drive and consistency.

Recent research indicates that teamwork is crucial key driver that influences patient experience (Aaronson et al., 2018; Carlson et al., 2022; von Knorring et al., 2020). For their part, Carlson et al. (2022) contended that healthcare is the "ultimate team sport" (p. 94) and sought to explore how to effectively build teams that would improve outcomes in both patient and employee experiences. Part of this process was to gather various disciplines (e.g., nursing, environmental services, food and nutrition services, etc.) together for frequent team meetings—meetings that practiced a "hands open, not fists closed" approach. This approach challenged members to identify how one team could serve the other team better before determining how the other team could first help them. This helped teams to then shape their commitments to each other. Carlson and colleagues (2022) described one of the significant outcomes of this process:

> One of the most impactful commitments was that nurses wanted to be able to trust that environmental services and food and nutrition would follow through on their duties to meet their expectations. Another was that environmental services and food and nutrition wanted to be included, respected, and considered part of the overall team. By including and recognizing both environmental services and food and nutrition in daily huddles, and having conversations around daily expectations of their efforts, trust was built. Environmental services and food and nutrition began to meet the nurses' expectations, and in return, felt respected and included (p. 96).

Thus, senior leaders who endorse such a concept to foster team development may find the approach instrumental to enhancing cohesiveness among staff, which in turn increases potential to meet or exceed patient experience goals.

## Micro Considerations: Setting the Stage for Nurse Managers

### *Nurse Manager Rounding on Staff*

Recent research indicates that when staff nurses have a positive perception of nurse manager caring, HCAHPS hospital ratings increase. Additionally, staff nurse perceptions of how much they visualize their managers during a shift leads to more positive perceptions of the extent to which nurse managers care (Kostich & Lasiter, 2021). Many of the nurses in this study indicated they have an "open door policy" with their staff and the strive to model best practices on their units. However, when questioned about their organizations' policies about structured rounding on their own staff (primarily to "check in" and ask about staff needs), only two of the 23 indicated a formal process for doing so. Yet limited research indicates that formal structured rounding on staff positions managers as transformational leaders who are visible, accessible, and approachable (Baker, 2010). Ultimately, structured rounding on staff enhances connections between staff and nurse managers. As such, staff are more receptive to coaching (Hugill et al., 2018), feel a greater sense of belonging on their units (King et al., 2022), and are more likely to achieve quality care outcomes and improved organizational performance (Blake & Bacon, 2020).

Although, as indicated by this study and demonstrated through extant research cited previously in the literature review, nurse managers struggle daily to find enough time to fulfill their duties, they truly care about tending to the needs and well-being of

their staff. A more selective approach to rounding on patients may allow for more time to round on staff, which in turn may yield more optimal patient experience results.

### *Breaking Away from the Silos*

Whether it be among units or interprofessionally, healthcare workers have traditionally worked in silos (ACH Media, 2020). For nurse managers and their staff, this equates to not looking beyond their own units for solutions. However, nurse managers in this study emphasized the need to lean on others within the organization to compare patient experience scores. They explained that areas of weakness on their own units may be effectively addressed by gaining insight from other nurse managers whose units were doing well on meeting their patient experience goals. Given that a lack of communication among healthcare workers leads to poor quality and decreased clinical outcomes (Friedrich et al., 2019), nurse managers would do well to rely on their peers to compare notes as they formulate strategies to enhance patient experience.

To take it a step further, a strong shared governance structure that engages and empowers frontline staff in decision making processes can also spur increased collaboration among units, as well as interprofessionally. Moreno et al. (2018) found that inclusion of clinical voices in making decisions boosts employee engagement and commitment. Additionally, on a larger scale shared governance can cast a light on those who aspire to lead and are eager to try innovative, creative ideas. In recent years shared governance has become more mainstream in healthcare settings and is key to the implementation of successful quality care initiatives (Olender et al., 2020). Given this, one might logically deduce that shared governance structures have great potential in

benefiting the patient experience, and in the process can help organizations to realize their patient experience goals.

### *Integration of Patient Experience into Clinical Care*

This study revealed that many nurse managers are so overwhelmed with the specific tasks of their job, including trying to tend to the needs of their staff, that they often miss the big picture—that patient experience, in its totality, is holistic in nature. Many nurse managers' made comments indicating that rather than viewing patient experience as completely integrated in the process of delivering clinical care, patient experience as a concept is a separate entity composed of "soft skills"—skills that take a backseat to more clinical tasks such as administering medication or taking vital signs. Yet considering that the primary cause of sentinel events in hospitals is due to breakdowns in teamwork and communication (The Joint Commission, 2023), these soft skills are instrumental in delivering safe and quality care.

Wolf (2020) envisions a path forward where patient experience evolves into a more encompassing "human experience" framework. Wolf, in his work with The Beryl Institute, drew from the reflections of hundreds of individuals throughout the world to determine the future of human experience. He found that framing the future of human experience in healthcare will require a transformation guided by three key changes: (a) a change in perspective from siloed and specialized to integrated and systemic; (b) a change in process from transactional to relational; and (c) a change in focus from aspirational to active. From this assessment several concepts emerged to set the foundation for the future of human experience. One key concept is to reframe how experience is measured, "from lagging to real-time indicators, ensuring a holistic

assessment of safety, quality, service, and engagement to demonstrate the value of care" (p. 9). To this point, Wolf indicates the current methods of patient experience measurement are piecemeal at best, and a laser focus on numbers sometimes leads to situations where those in healthcare figuratively do not see the forest for the trees.

Albeit the task orientation experienced by nurse managers (including the various initiatives they employ to boost or maintain patient experience scores) causes challenges to switching the focus from transactional to more relational in nature. Nurse managers largely manage settings that require them to be more reactive than proactive. Thus, nurse managers alone cannot steer this evolution of patient experience. Adapting to a human experience approach requires changes in organizational culture that must first be cultivated by an organization's most senior leaders. This would entail taking the focus off just the numbers. However, the one thing that nurse managers may strive to do, particularly in communicating with their own staff, is to frame patient experience as not so much another thing to do apart from everything else, but rather as the essence of the care itself.

## Theoretical Implications

This research was inspired by structurational divergence theory (SDT), which in the past has largely been used to examine nursing relationships. To my knowledge, this is the first study where SDT has been used to assess nurse manager perspectives about how accountability can impact communication within their organizations. In this section I will describe how SDT specifically applied to these findings and offer a proposed expansion to the theory.

**Structurational Divergence Theory and This Research**

Inspired by SDT (see Figure 3), this research sought to determine the existence of incompatible meaning structures and resulting negative spirals of communication, as is the structure of SDT. The SD Nexus was evident in this study due to the competing priorities between inpatient unit nurse managers and their organizations' senior leaders. Both sides want what is best for their organizations, though at times their competing priorities conflict. Senior leadership priorities center around the financial stability of their organizations, and such financial stability is fortified when organizations receive full reimbursement from insurance. However, this does not happen unless organizations meet the federal government's benchmarks for value-based purchasing, which include patient experience metrics.

Contrary to senior leadership's perspectives, nurse managers focus more on the tasks of providing quality care to the patients on their units, and achieving this goal in part necessitates making sure staff needs are met. Unfortunately, the conflict occurs when expectations by senior leaders do not align with staff needs. For instance, senior leaders may direct units to conduct hourly rounds on every patient, whereas staff know that it is at times nearly impossible for such a directive to be carried out—particularly when staff have several high acuity patients who need help to the bathroom, need baths, etc.

Nurse managers, for their part, feel caught in the middle, often conflicted because as much as they ally with their own staff, they are also obligated to carry out the directives that come down from the top. As to some of the scores, particularly the HCAHPS score measuring overall hospital rating, nurse managers often feel powerless because there is so much about the surveys that they cannot control.

These conflicting priorities lead to the SD Cycle, where negative spirals of communication create unresolved conflict and immobilization. Nurse managers expressed their frustration about the communication gaps that exist surrounding the patient experience scores. For instance, they explained that those most qualified to come up with solutions were those who are on the frontlines taking care of patients; yet they often felt their suggestions and recommendations were brushed off by senior leaders, who prefer a top-down approach to communication.

Another major source of contention was the continuous back and forth about staffing challenges on the units, as well as the lack of shared accountability for the scores. Nurse managers were frustrated that they could get the blame for a bad score—particularly as it pertains to overall hospital rating on the HCAHPS—when patients assessed those scores on factors other than the nursing care. For some, this lack of control over scores was an additional source of stress for nurse managers. Others relayed frustration that even their best efforts to manage the scores still did not budge the scores—so why bother at all to try to improve them?

They also pointed out that when staff efforts to boost scores proved futile, it would adversely impact morale on their units. Many nurse managers described how they would filter senior leadership messages about patient experience when communicating with staff as a way to essentially "soften the blow." Yet to the contrary, they felt staff lacked knowledge of the "why" behind the directives and that the lack of presence by senior leaders to communicate the why served to exacerbate the problem.

Overall, this study demonstrated the existence of conflict not only about the scores in of themselves but also about the larger issue of how patient experience should

be measured. Themes derived from the data indicate not only the incompatible priorities among structures but also the adverse communication dynamics that can occur as a result.

Additionally, the data provide food for thought on how SDT can be enhanced. When, exactly, does the SD Nexus become the SD cycle? Does it just occur, or is there an expanded process for this? On the basis of findings of this study, I propose such an expansion.

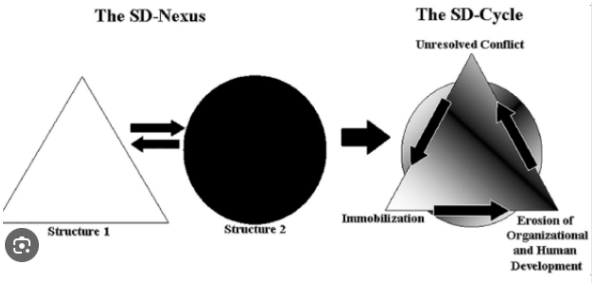


Figure 3: Structurational Divergence Theory

**Extending SDT**

From this study I propose an expanded process, or at least a segue, that occurs with the transformation of the SD Nexus to the SD Cycle. Initially, incompatible meaning structures exist (SD Nexus), but that existence can split into one of two directions. The proposed expansion to the theory (see Figure 4) outlines the phenomena that occur not only toward the path of structurational divergence but also for structurational convergence—where conflict is ultimately resolved.

This research has demonstrated that before the SD Nexus evolves into the SD Cycle, the process encounters a figurative "blind zone." The blind zone occurs largely from an exclusive top-down communication process that does not include feedback from the bottom-up. The rigid directives issued down the ranks from organizational leaders create a conflict for nurse managers struggling to manage the personal and professional

needs of staff. The blind zone is characterized by lack of awareness of others' challenges and no motivation to be enlightened or informed by these challenges. For instance, in this study the lack of a consistent presence by senior leaders to reinforce the "why" of patient experience or understand frontline staff challenges can create gridlock down the ranks. Likewise, when staff feel they are unsure of the why, have no voice in proposing solutions, and are not secure in providing feedback up the line, it can cause a workplace environment riddled with apathy and low staff morale. Thus, all levels of the organization—from senior leaders to nurse managers to frontline staff—are essentially blind to the challenges and trains of thought of others.

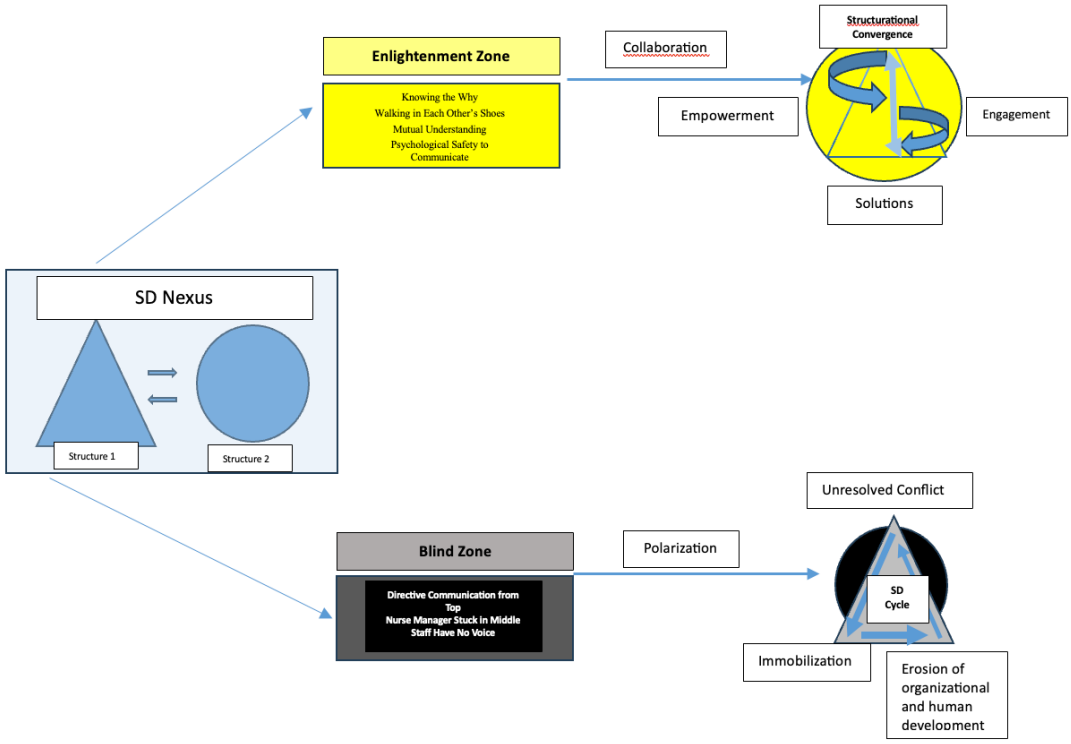


Figure 4: Structurational Divergence/Convergence Process Theory

For its part, this research aptly demonstrated nurse managers' concerns that they and their frontline staff were more positioned to follow orders from the top with no

questions asked, rather than to collaborate to determine priorities and attainable goals. Thus, they feel they have no voice and the challenges they face are not adequately understood. The blind zone creates an atmosphere of polarization, or an "us versus them" way of thinking, which eventually leads to the SD Cycle that represents a constant flux of unresolved conflict and, in turn, impedes organizational performance. With the SD Cycle, the figurative line is drawn in the sand, with each side staying on their side. The graphic depiction of the SD Cycle shows that the boundaries between structures still very much exist.

The SD Nexus, however, does not necessarily have to lead to the Blind Zone. With initiatives such as shared governance, structured rounding on staff, and efforts by senior leaders to consistently position themselves in the trenches to understand the challenges of nurse managers and their frontline staff, mutual understanding can occur. Not only can senior leaders gain a better understanding of the challenges on the units but also those on the units—nurse managers and their staff—can begin to understand senior leadership perspectives and the "why" behind patient experience initiatives. As this mutual understanding forms, it creates an atmosphere of enlightenment. When all levels within the organization are cognizant of the challenges of others, the SD Nexus process steers toward an Enlightenment Zone. Within the Enlightenment Zone, all levels have a voice at the table, and all perspectives are valued. This enables a more collaborative environment where everyone feels empowered to voice their opinions and propose solutions. As such, instead of a one-directional communication process that is prominent within the SD Cycle, a more fluid, cyclical communication process occurs. As such, the boundaries between levels, while still present, become more porous. With this fading of

boundaries, “us versus them” can become “we are all in this together.” As such, structurational convergence—where all levels are figuratively on the same page—occurs. With structurational convergence, all within the organization are empowered to build a solid foundation for best delivering quality care. It is quality care that tends to not only the clinical needs of patients but also to the spiritual and emotional needs they naturally have as human beings. For its part, this research illustrated nurse manager desires for such mutual understanding to occur. Few of the nurse managers interviewed expressed that the incompatible meaning structures they experienced channeled through the enlightenment zone. But for the handful of nurse managers who did feel they and their staff had the ear of senior leadership, they indicated that the more open communication processes better alleviated conflict and led to a better working atmosphere for getting the conflicting structures on the same page.

As Wolf (2020) eloquently conveyed, healthcare professionals are simply human beings caring for other human beings. As human beings, they value caring and personalized, relational connections that are characterized by good communication and respect. Such relationships are more likely to materialize when healthcare staff find themselves in a good place in their work settings. According to Carlson et al. (2023), experience is not just focused on clinical encounters “but crosses all touchpoints one has on their own care journey. This means the experience of the healthcare workforce is equally important in the experience conversation” (p. 3).

## Limitations and Future Directions

This research was designed to shed light on whether nurse managers’ experiences of accountability for patient experience measures create organizational communication

breakdowns that are ultimately detrimental to their overall organizational climates. This research adds to the body of literature because, although minimal research has examined clinician perceptions of patient satisfaction metrics (Calcaterra et al., 2017), this is the first study to my knowledge that that examines this issue from a nurse manager perspective. Additionally, although SDT has been abundantly explored within the nursing field, little—if any—research has considered this theoretical framework in the examination of nurse manager experiences.

One noteworthy contribution of this study is that it applies SDT—an organizational communication theory—beyond the realm of one individual organization. Typically, organizational communication research consists of case studies of individual organizations. Some might assert that pulling participants from multiple organizations would pose a limitation for the study. However, what some might say is a limitation could actually be a strength and a contribution to the literature, as it applies SDT in new ways—focusing on a single industry rather a single organization. Although not typical, I am not the first to explore SDT in a study that features participants from multiple organizations. A recent study by Millender et al. (2023) drew on SDT to explore organizational silence. This research featured 276 participants within 41 U.S. states representing a wide variety of industries.

Just as with the study by Millender et al. (2023), I feel my research was also warranted in its approach to feature participants from multiple organizations. The goal of my study was to gain a general understanding of the topic overall and to ascertain whether, as a collective, nurse managers experienced stress from their accountability for patient experience and whether such accountability shaped communication and conflict

within their organizations. Thus, the study sought to consider hospitals in general as one collective organization. It is completely feasible to replicate this study within one organization, though it would most likely need to be a larger hospital organization with sufficient nurse managers willing to participate. With this study, access to this many nurse managers within one organization was not possible. In the end, however, I believe my approach stretches the boundaries of how SDT can be applied, which I consider to be a noteworthy contribution.

This research, however, was not without limitations. For instance, all 23 participants in this study identified as female. Although the nursing profession is represented predominantly by females and only 9% of nurses are male (Konuch, 2022), approximately 13.5% of male nurses are in positions of leadership (Zippia, 2021). Ideally, this study would have contained male perspectives. Perhaps an opportunity for future research would be to replicate this study with insights from male nurse managers.

Additionally, although some of those interviewed expressed that the patients served by their organizations represented difficult patient demographics (i.e., inner city versus suburban hospitals), this study did not delve into this issue. Issues surrounding difficult patients, as well as abusive patients, did surface during the interviews, though not so much as to include within the findings. For future studies scholars may want to explore how varying demographic patient populations and social determinants of health impact nurse perspectives of patient experience measures.

Furthermore, the study did not specifically explore the impact of the COVID pandemic on patient experience accountability issues. Most nurse managers did respond that when the pandemic hit, patient experience efforts in general were placed on the

backburner, as that was a time of crisis that had most units in reactive mode. Others told stories about how their patients were more appreciative of their care than usual, simply because they were happy to be alive. By the time of this study, patient experience was back in the forefront of organizational priorities, and I felt that addressing the COVID angle was beyond the scope of this particular study. However, additional research specifically examining the impact of COVID on patient experience may serve to inform such issues down the road when subsequent pandemics occur.

Finally, an additional limitation came to light from member checking feedback, when the respondent indicated that it would be interesting to know how nurse manager stress from pressure to boost and maintain optimal patient experience scores may impact nurse managers' intent to leave. Although the literature review raised the issue that organizational expectations related to patient experience may be a factor in nurse managers' intent to leave, the interview protocol did not include a question on this, and this issue was not further explored in the findings. This is an unfortunate omission, as an additional question in the interview protocol could have addressed this. Additional research—perhaps using a quantitative methodology to elicit information from a greater volume of nurse managers—is warranted.

Now that this research has revealed specific issues of nurse manager accountability for patient experience measures, specifically pertaining its adverse impact on stress, communication, and conflict, a logical continuation of this research would be to use a modified measurement tool (based on an SD measurement tool developed by Nicotera et al., 2010) to measure SD (solely quantitatively or as part of a mixed methods approach) as it pertains to patient experience on a more widespread scale. This might

include both nurse managers who are accountable for the scores and frontline staff who are mandated to carry out various initiatives to manage the scores.

Despite the limitations to this study, they do not void the significance of my findings. This study, at minimum, scratches the surface of an issue that is ripe for further research. Additionally, it serves as a worthy foundation for scholars who may embark upon future studies that may explore organizational expectations for patient experience and how those expectations impact healthcare staff.

## Conclusion

As ultimately asserted by Carlson et al. (2023):

> The measures of experience matter. Yet, all too often, the metrics collected from patient experience surveys are the only data considered in measuring experience. This is a narrow view of experience that leaves organizations at great risk of missing all that ultimately influences the experience they provide and the richness of other means of feedback. To be clear, patient survey data, such as the HCAHPS survey results for hospitals in the U.S. do not equal experience; they reflect part of it (p. 11).

Without question, patient experience data can be useful in guiding efforts for improvement. What is at question is the degree to which organizational leaders focus on just the numbers. This research explores whether hospital organizations use patient experience scores as intended—to guide improvement—or whether organizations view scores as the "be all and end all," something to be "chased" to maximize reimbursement and, to a degree, save face among competitors. Such a narrow focus could ultimately be detrimental to hospital organizations by impeding their ability to view experience in a more holistic way and in turn putting undue pressure on the nurse managers (and the staff) whom hospitals rely upon to ensure the health and well-being of the human beings who need their care.

This study has demonstrated that, although patient experience as a concept is a worthy one, the measures of patient experience, particularly the societal and organizational priorities for measuring it, pose a source of stress and conflict for nurse managers. This study adds insight into some of these issues. Realistically, this research will not likely spur immediate change. Rather, given the lack of scholarly attention to this particular topic, the aim is to bring awareness to these issues and establish a foundation of research—one that examines whether current approaches to prioritizing measurement of the patient experience may do more harm than good.

## Disclosures

This research was funded in part by a grant provided by The Beryl Institute.

# APPENDICES

## Appendix A: Interest Questionnaire via Qualtrics

Hello, and thank you for your interest! Researchers at the University of Kentucky invite you to take part in a virtual (Zoom) interview about your experience as a registered nurse serving in a management capacity on an inpatient unit within the past five years. Specifically, we are interested in how you are/were held accountable for patient experience measures (e.g., HCAHPS), and how this accountability impacts the way you manage, as well as the way you communicate with others up and down the organization.

Your responses may help us to gain deeper understanding of the various challenges that nurses in management positions face. As such, the research could possibly "start a conversation" that would benefit others in the future.

For your time, you will receive a financial incentive in the form of a $75 Amazon gift card. The interview will take about 45 to 50 minutes to complete. Your responses to the survey will be audio recorded (for transcription purposes only, and you may opt to mute the video function) and will be kept confidential. Identifiable information will not be published in the study.

If you have any questions about the study, you may email me at lisa.huddleston@uky.edu.

If you are interested in participating in this study, please complete the information on the interest questionnaire below:

Name (will not be published in the study):

I am:

- Currently a registered nurse serving as a nurse manager or assistant nurse manager on an inpatient hospital unit
- Formerly a nurse manager, a registered nurse serving as a nurse manager or assistant nurse manager on an inpatient hospital unit within the past five years
- A registered nurse, but have not served in a leadership capacity on an inpatient unit within the past 5 years
- Not a registered nurse

In my tenure as a nurse manager (or assistant nurse manager), I:

- Assumed accountability for patient experience scores (such as HCAHPS) on my unit
- Am not familiar with patient experience measures such as HCAHPS
- Other:

For this research study:

- I am interested in participating and understand I will receive a financial incentive for my participation
- I haven't decided and would like to find out additional details from the person in charge of this study
- I do not wish to participate in this study

If you are or may be interested in participating, please include the contact information below:

Name:

Years as a Registered Nurse:

Years as a nurse manager:

Type of hospital that best describes where you have most recently or currently are a nurse manager:

- Small community hospital
- Large tertiary and/or teaching hospital
- Other:

Type of unit currently or most recently managed:

- Medical/surgical
- Transitional Care Unit (TCU)
- Intensive Care Unit (ICU)
- Other:

State of Residence:

Email (to best contact you):

Please indicate days and times that would be best for you to participate in an interview (note: we recommend that you participate in the interview away from your work setting to encourage more candid answers):

Morning (8am to noon) Afternoon (noon to 4 pm) Evening (5pm to 8 pm)

Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday

I live in (please specify time zone):

- Eastern Time Zone
- Central Time Zone
- Mountain Time Zone
- Pacific Time Zone

## Appendix B: Informed Consent Document

Consent and Authorization to Participate in a Research Study

**KEY INFORMATION FOR "AND THE SURVEY SAYS...: A QUALITATIVE EXPLORATION OF STRUCTURATIONAL DIVERGENCE FROM THE PERSPECTIVES OF NURSE MANAGERS WHO ARE ACCOUNTABLE FOR PATIENT EXPERIENCE MEASURES":**

**INTERVIEW INFORMED CONSENT FORM**

We are asking you to choose whether or not to volunteer for a research study about nurse manager perspectives on patient experience measures and how accountability for such measures impacts communication. We are asking you because you are a current or former nurse manager or assistant nurse manager who has been accountable for patient experience measures. This page is to give you key information to help you decide whether to participate. We have included detailed information after this page. If you have questions later, the contact information for the research investigator in charge of the study is below.

**WHAT IS THE STUDY ABOUT AND HOW LONG WILL IT LAST?**

The purpose of this study is to explore how nurse managers or assistant nurse managers experience accountability for their units' patient experience scores, and whether such accountability impacts communication processes within the workplace. Also, you will be asked demographic questions.

By doing this study, we hope to learn the extent to which accountability for patient experience scores contributes to nurse manager stress, as well as whether (and what type of) communication breakdowns occur in the workplace as a result of this accountability. Your participation in this research will last about 45 to 50 minutes for the interview.

**WHAT ARE KEY REASONS YOU MIGHT CHOOSE TO VOLUNTEER FOR THIS STUDY?**

You may gain a deeper understanding about how accountability for patient experience scores might impact nurse managers or assistant nurse managers, as well as their ability to communicate about patient experience issues. You will also receive a $75 Amazon gift card for your participation. You will receive the payment whether you finish the interview or not.

**WHAT ARE KEY REASONS YOU MIGHT CHOOSE NOT TO VOLUNTEER FOR THIS STUDY?**

Risks for participating in this study are minimal, as pseudonyms will be used and identifying information will not be included in the final results. You may experience some emotional stress discussing issues pertaining to patient experience measures. Another potential reason for not participating might be time constraints. For a complete description of risks, refer to the Detailed Consent.

**DO YOU HAVE TO TAKE PART IN THE STUDY?**

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any services, benefits or rights you would normally have if you choose not to volunteer.

**WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS OR CONCERNS?**

If you have questions, suggestions, or concerns regarding this study or you want to withdraw from the study contact Lisa Huddleston of the University of Kentucky, Department of Communication at Lisa.Huddleston@uky.edu..

If you have any concerns or questions about your rights as a volunteer in this research, contact staff in the University of Kentucky (UK) Office of Research Integrity (ORI) between the business hours of 8am and 5pm EST, Monday-Friday at 859-257-9428 or toll free at 1-866-400-9428.

**DETAILED CONSENT:**

**ARE THERE REASONS WHY YOU WOULD NOT QUALIFY FOR THIS STUDY?**

You do not qualify for the study if you are not a registered nurse who has served as a nurse manager or assistant nurse manager within the past five years. You also do not qualify if while in this role you were not accountable for patient experience scores.

**WHERE WILL THE STUDY TAKE PLACE AND WHAT IS THE TOTAL AMOUNT OF TIME INVOLVED?**

The interview will take place on Zoom, and you will have the opportunity to mute the video. You will need to participate in one interview during the study that will take approximately 45 to 50 minutes of your time.

**WHAT WILL YOU BE ASKED TO DO?**

- The interview will be about 45 to 50 minutes. You will be asked to answer about 20 questions about your experience as a nurse manager/assistant nurse manager who has been accountable for patient experience scores. You can choose to skip

questions at any time and do not have to answer any question that makes you uncomfortable.

- The data will be collected via one interview that will take approximately 45 to 50 minutes. There are no experimental procedures taking place. The interview will be audio recorded
- The interview will take place on Zoom. You will have the option to mute your video and change your screen name to something that will ensure your anonymity and protect your confidentiality. The interviewer will stay on video for the entire interview. The audio of the interview will be recorded through Zoom, as well as a stand-alone recorder (as a backup).
- The principal investigator will provide a summary of the study results to a random sample of study participants. As such, you may be selected to review the summary of study results and provide feedback or comments. If you are chosen, the principal investigator will contact you via email to ask whether you would be willing to do this. Review of the study results is completely voluntary, and you may refuse to do this. If you do agree to review the summary, the principal investigator will email the summary to you, and participants will provide feedback to the principal investigator by email.

**WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?**

Risks for participating in this study are minimal. One foreseeable risk for participants is experiencing some psychological or emotional stress from discussion of your experiences with being accountable for patient experience measures. However, if you become upset and wish to terminate the interview, the interview will be terminated at your request.

**WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?**

We do not know if you will get any benefit from taking part in this study. However, some people have experienced a benefit or satisfaction from knowing the experiences they share may add to the body of research, which in turn can promote dialogue about how organizations prioritize patient experience scores. You may also benefit from learning about the experiences of others who are in similar situations.

**IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?**

If you do not want to take part in the study, there are no other choices except to not take part in the study.

**WHAT WILL IT COST YOU TO PARTICIPATE?**

There are no costs associated with taking part in this study.

**WHO WILL SEE THE INFORMATION THAT YOU GIVE?**

When we write about or share the results from the study, we will write about the combined information. We will keep your name and other identifying information private. I will make every effort to prevent anyone who is not on the research team from knowing you gave us information, or what the information is. To protect confidentiality, no personally identifying information will be used from the participants, unless reportable information is provided. Transcripts will not contain any identifying information. The only people who will access the identified data will be me and my faculty advisors. The audio files from the interviews will be destroyed after transcription is complete. The data will be stored electronically, in a password-protected OneDrive folder. In addition to Zoom transcription, a third-party transcription service (temi.com) will transcribe the interviews. Any identifiable information provided during the interview will be deleted before the audio recording is sent to the transcription service (temi.com) Zoom will be used to record interviews, and interviews will also be recorded with a Sony audio recorder. The audio recording will be transferred from the recording mechanism to the One Drive immediately following the interview and then deleted from the recording device. The contact information that you provide (e.g., email) will be destroyed upon member checking of results (where participants are randomly chosen to review a summary of the study results).

You should know that in some cases we may have to show your information to other people if it talks about child/elder abuse, abuse of patients, or sexual assault.

For example, the law may require or permit us to share your information with:

- a court or agencies, if you have a reportable disease/condition.
- authorities, such as child or adult protective services, if you report information about a child or elder being abused.
- authorities or a mental health professional if you pose a danger to yourself or someone else (e.g., suicidal thoughts).
- If you state reportable information during the interview, I will go back to the contact information log and immediately report your contact information to the authorities. After each interview, the temporary contact information log will be destroyed. There will not be a long-term master list to your contact information.

  To ensure this study is conducted properly, officials from the University of Kentucky may look at or copy pertinent portions of records that identify you. We will make every effort to safeguard your data, but as with anything online, we cannot guarantee the security of data obtained via the Internet. Third-party applications used in this study may have Terms of Service and Privacy policies outside the control of the University of Kentucky.

  Data may be used in external grant applications in the future. If data is used, it will be in a de-identified aggregate summary report.

  Identifiable information includes the name of the participant, the name of co-workers or other colleagues, the names of other identifiable places, people, and

businesses, and the participant's demographics. Identfiable information will be redacted from the recordings by the PI prior to transcription by a third-party service (temi.com). All identifiable information will be deleted once the research project is complete.

**CAN YOU CHOOSE TO WITHDRAW FROM THE STUDY EARLY?**

You can choose to leave the study at any time. You will not be treated differently if you decide to stop taking part in the study. If you choose to leave the study early, data collected until that point will remain in the study database and may not be removed.

The investigators conducting the study may need to remove you from the study. You may be removed from the study if:

- you are not able to follow the directions,
- we find that your participation in the study is more risk than benefit to you.

**WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?**

You will receive a $75 Amazon gift card for taking part in the interview portion of this study. If you withdraw early or choose to skip questions, you will still receive the gift card.

**WHAT ELSE DO YOU NEED TO KNOW?**

If you volunteer to take part in this study, you will be one of about 25 to 30 people to do so. The PI will be recruiting participants from throughout the country.

If you would like to receive them, the PI will provide you with copies of the results of this research.

Please note that you will be asked to provide your verbal consent. If you have questions about the research, please contact the principal investigator as soon as possible.

The principal investigator for this study is Lisa Carpenter Huddleston, a doctoral candidate in the College of Communication and Information at the University of Kentucky. The advisor who is guiding this research is Dr. Derek Lane (Derek.Lane@uky.edu).

This study is being funded in part by a grant from The Beryl Institute.

## Appendix C: Interview Protocol

### Introductory Questions

- Tell me what a typical day at work is/was for you.
- How would you personally define the concept of patient experience?
- Can you share with me your involvement with patient experience measures (such as the HCAHPS)?
    - Probe: What have your experiences been with that as a nurse manager within your organization?
- How has the organization talked to you about patient experience scores?
    - Probe: Were you expected to boost or maintain scores?
        - If yes, how so?
- Have your experiences with managing patient experience scores impacted your stress?
    - Probe: If yes, how so?
        - Probe: If yes, how does this stress compare to other stressors of the job?
    - Probe: If no, what types of things stress you out more?

### Communication

- Describe to me some typical scenarios about how you communicate to your staff about patient experience and patient experience scores.
- Can you tell me a story about a challenging communication situation that unfolded when you communicated to your staff about patient experience scores?
- What kind of experiences can you share about the types of encounters that have occurred when communicating with senior leaders about patient experience scores?
- Imagine you have been put in charge of improving the way that your organization measures patient experience.
    - Probe: Based on your experience, what would you recommend? Why?
    - Probe: What would you change? Why?
    - Probe: What should stay the same? Why?
- To ensure that patients have the best possible experience on your unit, what would communication about the organization's patient experience goals look like?
    - Probe: How would that look different from the current reality?

### Structurational Divergence

- In your opinion, do current patient experience measures accurately measure the actual patient experience?
    - Probe: If yes, how so?
    - Probe: If not, why not?

- Share with me an instance where you felt efforts to boost or maintain scores impacted patient care.
    - Probe: For the better?
    - Probe: For the worse?
- What would you like for senior leaders to know about the challenges you face trying to manage your unit's patient experience scores?
- Have you ever felt conflicted between management's goals to attain desired scores and the needs of your staff?
    - Probe: If yes, how so?
    - Probe: If yes, how did you manage this conflict?
    - Probe: If no, why not?

**Closing Questions**

- What have I not covered that you think is important to add about this subject?
- What advice do you have for other nurse managers or new nurse managers who must deal with being accountable for patient experience scores?

**Demographic Questions**

- How long have you been accountable for patient experience metrics?
- How long have you been with (or were with) the organization for which you serve(d) as a nurse manager or assistant nurse manager?
- What is your age?
- Where do you live (state/region)?
- Of which gender do you currently identify?
- What is your race?
- What is your ethnicity? (Hispanic/Non-Hispanic)?

## Appendix D: Acronyms

- **ACA**: Affordable Care Act
- **AHRQ**: Agency for Healthcare Research and Quality
- **AIDET**: communication framework that is an acronym for acknowledge/introduce/duration/explain/ thank
- **AONL**: American Organization for Nursing Leadership
- **CMS**: Centers for Medicare and Medicaid Services
- **C.O.N.N.E.C.T.**: communication framework that is an acronym for contact (e.g., smile, eye contact); opening greeting (e.g., "good morning"); name (introduce yourself and title/role); needs (assess expressed or unexpressed needs); explanation (explain and set expectations); closing statement (ask if there is anything else you can do); and thank (thank the patient).
- **HCAHPS**: Hospital Consumer Assessment of Healthcare Providers and Systems
- **ICE**: Interpersonal Care Experience
- **IHI**: Institute for Healthcare Improvement
- **SD**: Structurational Divergence
- **SDT**: Structurational Divergence Theory
- **VBP**: value-based purchasing

## Appendix E: HCAHPS Survey Questions

Source: https://hcahpsonline.org/globalassets/hcahps/quality-assurance/2023_survey-instruments_english_mail.pdf

**Your Care from Nurses (Responses: Never, Sometimes, Usually, Always)**

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
2. During this hospital stay, how often did nurses listen carefully to you?
3. During this hospital stay, how often did nurses explain things in a way you could understand?
4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?

**Your Care from Doctors (Responses: Never, Sometimes, Usually, Always)**

5. During this hospital stay, how often did doctors treat you with courtesy and respect?
6. During this hospital stay, how often did doctors listen carefully to you?
7. During this hospital stay, how often did doctors explain things in a way you could understand?

**The Hospital Environment (Responses: Never, Sometimes, Usually, Always)**

8. During this hospital stay, how often were your room and bathroom kept clean?
9. During this hospital stay, how often was the area around your room quiet at night?

**Your Experiences in This Hospital (Responses: Never, Sometimes, Usually, Always – except for question 12, which is a yes/no response)**

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?
11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
12. During this hospital stay, were you given any medicine that you had not taken before?
13. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
14. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

**When You Left the Hospital (Responses: Yes/No—except for question 15)**

15. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?
16. 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?
17. 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?

**Overall Rating of the Hospital (Response: 0-10 for question 18; Definitely No, Probably No, Probably Yes, Definitely Yes for question 19)**

18. 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?
19. Would you recommend this hospital to your friends and family?

**Understanding Your Care (Response: Strongly Disagree, Disagree, Agree, Strongly Agree; question 22 additional choice of "I was not given any medication when I left the hospital")**

20. 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.
21. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
22. When I left the hospital, I clearly understood the purpose for taking each of my medications.

**About You**

23. During this hospital stay, were you admitted to this hospital through the Emergency Room? (Response: Yes/No)
24. In general, how would you rate your overall health? (Response: Excellent, Very Good, Good, Fair, Poor)
25. In general, how would you rate your overall mental or emotional health? (Response: Excellent, Very Good, Good, Fair, Poor)
26. What is the highest grade or level of school that you have completed? (Response: 8th grade or less, Some high school but did not graduate, High school graduate or GED, Some college or 2-year degree, 4-year college graduate, More than a 4-year college degree)
27. Are you of Spanish, Hispanic or Latino origin or descent? (Response: No, not Spanish/Hispanic/Latino; Yes, Puerto Rican; Yes, Mexican, Mexican American, Chicano; Yes, Cuban; Yes, other Spanish/Hispanic/Latino)
28. What is your race? Please choose one or more. (Response: White, Black or Africcan American, Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native)
29. What language do you mainly speak at home? (Response: English, Spanish, Chinese, Russian, Vietnamese, Portugese, German, Tagalog, Arabic, Some other language—specify)

## Appendix F: Quirkos First-Round Coding

| Title | quotes |
|---|---|
| Good communication | 19 |
| Optimal Patient Experience | 10 |
| Managing PX Scores | 7 |
| SD Nexus - communication conflict | 9 |
| Task orientation | 12 |
| nurse manager expectations by management | 32 |
| NM stress from PX | 6 |
| challenging communication with staff | 52 |
| SD cycle - communication limbo/negative spirals | 10 |
| catch 22 | 20 |
| scores reflecting px | 24 |
| patient care | 8 |
| px score strategy | 17 |
| NM role conflict | 10 |
| Communication | 25 |
| Patient Experience Challenges | 14 |
| Patient wants and needs | 24 |
| HCAHPS limitations | 41 |
| initiatives to improve PX | 37 |
| staff nurse morale | 45 |
| communication with management | 25 |
| HCAHPS benefits | 5 |

| Title | quotes |
|---|---|
| NM understanding of HCAHPS | 1 |
| NM rounding on staff | 22 |
| context | 2 |
| Taking the temperature of staff | 4 |
| viewing PX holistically | 19 |
| self-imposed stress | 14 |
| communication with staff about PX | 37 |
| Understanding HCAHPS | 5 |
| Can't be everywhere | 5 |
| effecting change | 4 |
| PX as hospitality | 8 |
| NM learning about HCAHPS | 4 |
| out of my control | 18 |
| sr leader communication to NM | 9 |
| Collaboration between structures | 4 |
| nights and weekends | 5 |
| empathy | 7 |
| shared governance | 10 |
| comparing among units | 11 |
| operating in silos | 1 |
| NM alliance with staff | 7 |
| HCAHPS qualitative comments | 16 |
| NM in the middle | 13 |
| peer feedback | 3 |

| Title | quotes |
|---|---|
| HCAHPS challenges | 48 |
| Impact of Covid | 21 |
| NN stress from accountability | 44 |
| System approach to scores | 25 |
| Nurse Manager as insulator | 19 |
| Presence | 39 |
| Perception of PX by NMs | 36 |
| NM rounding on patients | 27 |
| key words and scripting | 24 |
| Blame Game | 37 |
| Modeling PX by NM | 12 |

Appendix G
Thematic Codes

| Nurse Manager Stress | | | |
|---|---|---|---|
| **Theme** | **Theme Conceptualization** | **Example Excerpt** | **Sample First-round Codes from Which Theme was Synthesized** |
| **Stress as Self-Imposed** | The extent to which stress is internalized due to a nurse manager's innate tendency to be a high achiever. | *"It's not about the staff, it's about me. It stresses me more because I want to keep the high expectations."* | • Nurse manager stress from patient experience<br>• Managing patient experience scores<br>• Nurse manager stress from accountability |
| **Disparity over Dollars** | The extent to which nurse managers worry reimbursement penalities assessed for not meeting patient experience goals will impact staff and material resources. | *"If all those things are happening because I don't care about patient experience, eventually there's not really the money to pay the staff. So then we look at more staffing issues. There's not money for equipment. So then things are broken or we just don't have it." anymore.* | • Nurse manager stress from accountability<br>• HCAHPS challenges<br>• Nurse manager expectations by management |
| **The Toll of No Control** | The extent to which nurse managers feel they have no power over managing the patient experience scores for their units. | *"You can have a perfectly great experience and give it an eight because, you know, there's always room for improvement, but the fact that it's* | • "Out of my control"<br>• HCAHPS limitations<br>• Catch-22<br>• Patient knowledge of what's at stake |

| Nurse Manager Stress | | | |
|---|---|---|---|
| **Theme** | **Theme Conceptualization** | **Example Excerpt** | **Sample First-round Codes from Which Theme was Synthesized** |
| | | *weighted that way (means) that an eight is essentially, you know, a zero."* | • Perception of patient experience b nurse managers |
| **The Flawed Path to Perfection** | The pressure that nurse managers feel to bring in near perfect or higher scores, even when current scores are good. | *"...every year the expectation goes up even higher. I think (senior leadership) saying okay, you're doing excellent and we would like for you to maintain that and that's your goal. But instead it's like, oh well, you're at 99 (percentile). We want you to be at a hundred this year."* | • Senior leader communication to nurse managers<br>• Communication with management |
| **Letting Go** | The extent to which nurse managers become resigned to the fact that they can't always meet their patient experience goals. | *"I would say the score is only one way to evaluate overall performance. You know what you do well or what you need to improve. Take it as a tool (and don't) let it control you."* | • Nurse manager stress from accountability<br>• Managing patient experience scores |

| Nurse Manager Communication | | | |
|---|---|---|---|
| **Theme** | **Theme Conceptualization** | **Example Excerpt** | **Sample First-round Codes from Which Theme was Synthesized** |
| **Presence is the Essence** | The extent to which nurse managers model desired behaviors and perceive their own visibility and the visibility of senior leaders on the nursing unis and among peers. | *"You can't be out on the floor 24/7 because the fact of the matter is you have schedules, you have payroll, you have leadership meetings, you have the tasks that you have to do. Helping (staff) be able to see that—that is also a challenge."*<br><br>*"I think the understanding as far as what is truly going on outside of administrative offices is important. That's why I think it's very important for leaders to engage with the staff—to have a true understanding of what frontline staff members are going through."* | • Nurse manager in the middle<br>• Can't be everywhere<br>• Good communication<br>• Nurse manager role conflict<br>• Modeling patient experience by nurse manager<br>• Leadership walking in their shoes<br>• Nights and weekends<br>• Presence<br>• Operating in silos<br>• Collaboration between structures<br>• Comparing among units |
| **Formal Communication** | The extent to which nurse managers use formal communication channels such as email, staff meetings, or daily huddles to communicate about | *"We have shift huddles three times a day. We share at least one positive and one negative patient comment, as well as our score. If we have a major update, it's* | • Communication<br>• Communication with staff about patient experience<br>• Good communication |

| Nurse Manager Communication | | | |
|---|---|---|---|
| **Theme** | **Theme Conceptualization** | **Example Excerpt** | **Sample First-round Codes from Which Theme was Synthesized** |
| | patient experience to their staff. | *communicated in our weekly updates that we send out every Friday—where we stand with our scores, as well as the highlight for (the past) two weeks."* | • Nurse manager rouinding on staff |
| **Communicating the Why** | The extent to which nurse managers and their staff understand organizational leaders' motives to boost and maintain patient experience scores | *'I guess I feel like senior leadership, at a lot of places, doesn't give that information to staff. I don't know if they don't feel like they think it would be relevant to them, or if they feel like they wouldn't understand it. It's, you know, kind of a condescension thing."* | • Frontline knowing the why<br>• Nurse managers learning about HCAHPS<br>• Challenging communication with staff |
| **Sticking to the Script** | The extent to which nurse managers coach their staff to use scripted words that will influence the scores that patients give them. | *"I want to make sure when somebody's asked a question, sometimes if they don't hear the same word in it, they may not know what somebody's doing. … It's just trying to get staff to use that verbiage…because if you ask somebody a question two different ways, you're gonna get* | • Patient experience score strategy<br>• Key words and scripting<br>• Empathy |

| Nurse Manager Communication | | | |
|---|---|---|---|
| **Theme** | **Theme Conceptualization** | **Example Excerpt** | **Sample First-round Codes from Which Theme was Synthesized** |
| | | *two different answers."* | |
| **Preserving Staff Morale** | The extent to which nurse managers feel that keeping staff happy is key to maintaining optimal patient experience. | *"I feel like I'm the buffer. I feel like it's my responsibility. Like, a dam breaks and I'm the levy. I feel like it's my responsibility to soften that blow to the staff. That doesn't mean I don't hold them accountable. … It's just now I say things to them rather than, "You're doing this wrong—do better.' It's 'Hey, what can we do to work on this together?'"* | • Staff nurse morale<br>• Frontline having a voice<br>• Nurse manager as glue<br>• Nurse manager alliance with staff<br>• Nurse manager as insulator<br>• Taking the temperature of staff<br>• Recognition |

| Nurse Manager Perceptions of Conflict | | | |
|---|---|---|---|
| **Theme** | **Theme Conceptualization** | **Example Excerpt** | **Sample First-round Codes from Which Theme was Synthesized** |
| **The Staffing Saga** | The frustration that nurse managers feel when they feel they do not have enough staff to impact patient experience scores. | *"I guess at times, like, there's such a big push that we have to, you know, get these scores. But then you're realizing okay, we've got to get these scores, but we're working like 10 nurses short this shift. What are you expecting?"* | • Task orientation<br>• Nurse manager expectations by management<br>• Challenging communication with staff<br>• Patient care<br>• SD cycle (communication limbo, negative cycles) |
| **The Blame Game** | The extent to which nurse managers are frustrated by their sole accountability for patient experience scores, as they claim other non-nursing staff impact patient experience just as much. | *"We could do the best we can. That might help a little bit. But if the food's not great, the environment's not good and there are delays in testing, nurses could do everything they can but that will impact the score.".* | • Challenging communication with staff<br>• Patient experience challenges<br>• The blame game<br>• Frontline having a voice |
| **Health versus Hospitality** | The extent to which nurse managers question whether patients' hospitality expectations diminish the care process. | *"I feel like the hospital has moved into the hospitality industry. You want to have the best experience, but I think some of these expectations are just unrealistic. I don't think we fully grasp what* | • Patient wants and needs<br>• Patient care<br>• Managing patient experience scores |

| Nurse Manager Perceptions of Conflict | | | |
|---|---|---|---|
| **Theme** | **Theme Conceptualization** | **Example Excerpt** | **Sample First-round Codes from Which Theme was Synthesized** |
| | | *their expectations are. You know, we're a place of healing. It's not like you're going to get a Hilton five-star resort."* | |
| **Do This—Do That** | The extent to which nurse managers feel organizational demands to launch patient experience improvement initiatives is excessive | *"So you feel like they're just kind of throwing you all these initiatives, and without any thought. I mean, there's great thoughts and I think there's great reasons behind them, but I don't think they always get enough frontline feedback about what they can fit into their day."* | • Initiatives to improve patient experience<br>• Nurse manager role conflict<br>• Nurse manager expectations by management<br>• Scores reflecting patient experience<br>• Patient experience score strategy<br>• Nurse manager rounding on patients |
| **Patient Experience as Piecemeal** | The extent to which nurse managers view (or don't view) patient experience as a holistic concept. | *"Certainly, right now, if I demanded as much attention to patient experience, I would have no nurses left. It's a balancing game of how do I meet the team members' needs and how do I meet the patients' needs? Because sometimes those are diversely opposite."* | • Managing patient experience scores<br>• Staff nurse morale<br>• Task orientation |

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# VITA

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### Education

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**Proposal Manager**
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July 2013-March 2014
**Freelance Writer**
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**Manager of Communication**
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August 2005-August 2010
**Manager of Communication and Grant Writing**
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## Publications

**Huddleston, L**. & Sajjad, M. (2022). A comparison of COVID-19 related Tweets disseminated by the Centers of Disease Control and the World Health Organization during the initial months of the pandemic. *American Behavioral Scientist,* 00027642221118296.

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