

"It's the People that Make the Environment Good or Bad:" *The Patient's Experience of the Acute Care Hospital Environment*

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Abstract:

A review of contemporary nursing research reveals a tendency to focus on select aspects of the hospital environment such as noise, light, and music. Although studies such as these shed light on discrete aspects of the hospital environment, this body of literature contributes little to an understanding of the entirety of that world as the patient in the sickbed experiences it. The purpose of the study detailed in this article was to describe the patient's experience of the acute care hospital environment. Nondirective, in-depth phenomenological interviews were conducted, then transcribed verbatim, and analyzed for themes. Against the backdrop of "I lived and that's all that matters," there were 3 predominant theme's inpatients' experience of the acute care environment: (1) disconnection/connection, (2) fear/less fear, and (3) confinement/freedom. In this environment, human-to-human contact increased security, and power in an environment that was described as sterile, disorienting, and untrustworthy. Acute and critical care nurses and other caregivers can use, the findings to create less noxious hospital environments.

KEYWORDS: acute care, critical care, hospital environment, nurse-patient relationship

Article:

Florence Nightingale¹ is considered the first researcher to study the hospital environment. She wrote extensively about aspects of the environment such as ventilation, light, noise, variety, bed and bedding, and cleanliness.² Since her pioneering work, however, few researchers have sought to expand that knowledge base. A review of contemporary nursing research revealed a tendency to focus on discrete aspects of the environment such as noise, light, music, and environmental factors related to sleep disturbances.³⁻⁹ Some researchers examined hospital sound levels using stress or stimulus-response theoretical frameworks. Increased environmental sound caused increases in patients' physiological measurements such as heart rate and blood pressure.⁶

This body of literature does not tell us what aspects of the hospital environment are most salient to patients themselves. Little is known about patients' own perceptions of the hospital world in which they are involuntarily immersed due to illness, accident, and/or disabilities. Initial clues were obtained in a 2002 study¹⁰ in which psychiatric patients were interviewed, as well as medical-surgical patients. The meaning of the hospital environment was quite different for the two types of patients. This unexpected finding led to additional data collection on psychiatric patients" and suggested the need for more extensive examination of medical-surgical patients as well.

Methodology

The purpose of this study was to describe the medical-surgical patient's experience of the acute care hospital environment. Since it was the perception of the acute care hospital environment that was the phenomenon of interest, an existential phenomenological approach utilizing the method developed by Pollio et al" and Thomas and Pollio¹³ was employed. Existential phenomenology seeks to "explicate the essence, structure, or form of both human experience and human behavior as revealed through essentially descriptive techniques."^{14(P6)} Pollio

et al¹² describe the use of the phenomenological interview as one way to explore lived experience. The first step in this method is to perform a bracketing interview prior to data collection to identify the researcher's presuppositions. The open-ended interview question was: "What stands out to you when you think about the acute care hospital environment?" The authors' bracketing interviews were audiotaped, transcribed, and analyzed in an interpretive research group. Analyses of these bracketing interviews revealed a consensus opinion of the researchers that having family with you in the hospital is a must and that order in the physical environment is a reflection of the staffs order and efficiency. Additionally, one researcher revealed an expectation of possible errors by nursing or ancillary staff and a belief that nurses would not take the time to see the patient as an individual.

Participants

A purposeful sampling design was employed to obtain participants with varying demographic characteristics who had been patients in an acute care hospital setting. An advertisement was placed in a weekly university newspaper that yielded more participants than needed. Participants were included in the study if they reported they had been medical-surgical patients in a hospital setting and were willing to talk about their experience. Participants were interviewed posthospitalization to decrease the chance of their perceiving further threats to safety and security and to protect against potential social desirability issues that may occur when nurses interview patients.¹⁵ There was no prespecified time period between the hospitalization and the interview because "in phenomenological research, the description of an experience as it emerges in a particular context *is* the experience."^{12(p31)}

Participants were English-speaking individuals over the age of 21 who were not cognitively impaired or experiencing physical distress at the time of the interview. The sample was comprised of 20 participants ranging in age of 24 to 90. Seven of the participants were African American; 13 were EuroAmerican, 7 were men, and 13 were women. Participants' reasons for hospitalization varied, but were all medical and surgical in nature.

Data Collection

Data collection occurred between November 2003 and February 2004. Participants were asked to describe, in as much detail as possible, what stood out for them or what they noticed about the acute care hospital setting. The specific research question was: "What stands out to you when you think about the acute care hospital environment?" Follow-up questions such as, "Tell me more about [the specific experience served only to clarify descriptions. Demographic information was obtained immediately after informed consent was given and before the interview began. Interviews were audiotaped and later transcribed verbatim. All interviews took place in the researchers' offices. Interview length varied from 45 minutes to 90 minutes.

Ethical Considerations

The study was reviewed and approved by the university's institutional review board. Written informed consent was obtained from those willing to participate. Participants were compensated \$10 to participate in the study. Names and references to places were changed to protect the identity of the participants. All research materials including audiotapes, informed consent forms, and transcripts were maintained under lock and key by the principal investigator.

Data Analysis

The data were analyzed using the systematic data analysis method described by Pollio et al¹² and Thomas and Pollio,¹³ illustrated in Figure 1. All 20 transcripts were read aloud and subjected to a line-by-line analysis in an interpretive research group, in which each member signed a confidentiality pledge. The researchers took notes of the discussion of the group. The major outcome of these readings was development of a thematic description for each transcript. An initial thematic structure was presented to the research group to enhance rigor, and interpretations from the research group were considered in addition to re-reading all transcripts before finalizing the thematic structure. The formalized thematic structure was presented to two study participants for validation. The participants who reviewed the thematic structure confirmed that it was representative of their experiences of the acute care hospital environment.

Findings

"I Lived and That's All That Matters"

The patient's experience of the acute care environment is grounded in the overarching belief that "I lived and that's all that matters." When asked to talk about their hospital experience, survival itself pervades patients' consciousness. Living beyond the confines of the hospital was the most significant indicator, from the patient's perspective, of quality care. As shown in the following text, the acute care environment produces many disturbing feelings and perceptions. Interestingly, patients often minimize these concerns, stating that "my greatest concern was dying." For example, one participant who clearly minimized her negative experiences with nursing care reported: "She was real rough with me. Not very nice. 'Cause my mom was there and my mom was like, 'you know, if you just stop, I'll take care of her, I'll clean her up, I'll change her sheets 'cause you're killing her. '... She [the nurse] could have been a lot more careful. But other than that, it's always been great." Another participant said, "I don't want anybody to lose their job. My health was the main, the most important thing, but still, it's like even though they were bad, there were other nurses that came in behind them that were good." Against the backdrop of "I lived and that's all that matters," the 3 dominant themes in the patient's experience of the acute care hospital environment were: (1) disconnection/connection, (2) fear/less fear, and (3) confinement/freedom. In the following paragraphs, verbatim quotations from the transcripts illustrate each theme.

DISCONNECTION/CONNECTION: The patient's experience of the acute care environment was overwhelmingly described in human-to-human relational terms. The disconnection or connection to nurses and other staff was a crucial element. For example, "It's the people that make the environment good or bad" and "I think it's the staff that make or break a patient's stay." Human-to-human contact increased security and power in an environment that was described as sterile, disorienting, and untrustworthy. Putting it simply, one participant said, "The relationship makes the environment better." Another participant said, "Had the attitudes been different, I could have dealt better with the inconveniences [of the hospital]."

Participants described several aspects of relationships with caregivers that were positive. Participants liked friendly, attentive, and encouraging nurses. These attributes increased comfort and feelings of being cared for. One participant said, "I'm going to tell you, when you are hurting and anyone is being nice to you, [it] is wonderful, you know." Participants believed that "caring," "nice," "friendly," and "attentive" nurses contributed to better health outcomes: "Ninety-five percent of the cure is tenderness, you know ... I think the biggest part of the cure is the caring" and "Matter of fact, the reason that I guess I was willing to get up, and stand up on that left leg, after the operation, was the fact that the nurses were nice to me." Many positive connections were made by nurses through nonverbal actions. For example, "It was made clear to me [by the nurses] ... this wasn't said, but actions speak louder than words. 'I'm not here to help you because this is my job ... this is what I love, this is what I'm called to do. So you are important to me as a fellow human being.'" The following story illustrates this theme:

[One of my hospitalizations] was very positive. Very attentive nurses, very friendly. I remember one afternoon I had asked for a milkshake and it was change of shift time, and the nurse was very friendly. She said, 'I'll call this in to the cafeteria and they'll deliver it' and the milkshake didn't come and my phone rang, maybe an hour later, and she was at home and had realized that she forgot to call in the milkshake. So she had called to tell me to hang tight that she had already called the cafeteria and realized that after she left she had not ordered the milkshake and that it would be delivered soon, and it was. So that extra touch made the hospitalization a lot less taxing.

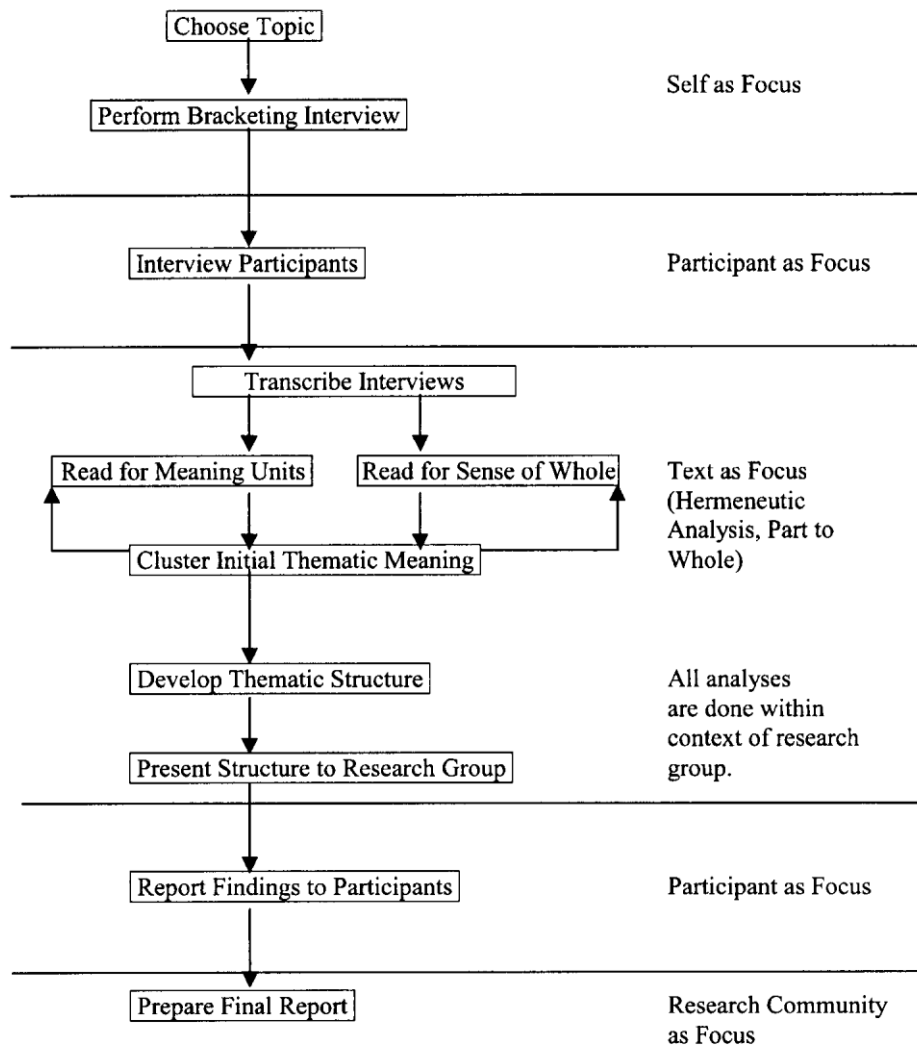


Figure 1. Diagram of research method. Reprinted with permission from Pollio, Henley, and Thompson.^{12(p60)}

The term "friendly" (and "unfriendly") was used repeatedly by many of our research participants in their descriptions of connectedness to caregivers in the acute care environment. Friendly nurses made a positive impact on the patient's experience of the environment. For example, "[A] friendlier staff. I mean they seemed to enjoy what they were doing. And in spite of the fact that I was in a lot of pain and hurting and those are not times that you feel your best, obviously, they seemed to make it a little easier. I didn't mind seeing them come in the room." Another participant described his vivid memory of "a friendly nurse on day shift" as follows:

There was a very friendly nurse on day shift, just bubbly, you know, you looked forward to her coming in, she went and made sure you got your food, asked how you were doing that day, you know, made sure you knew her name. And she was really friendly. As I was leaving the hospital, I remember her waving from the nurse's station, just very pleasant. The type of person you want to be around when you aren't feeling well. She was rather contagious with smiles and friendliness.

Research participants spoke repeatedly of the positive impact that "just checking-in" had on them during their hospitalization. They were most impacted by brief and frequent "checks." Participants did not describe lengthy conversations with specific nurses. Social conversation that lasted "just a couple of minutes" was reported to be extremely beneficial. One participant said, "Chitchat is good; it makes me feel less afraid, less alone." Nurses who "stuck their head in the door to see how I was doing" increased patients' sense of safety and security. Participants described positive connections made by nurses who "checked in" on them for no apparent reason. For example, "it just seems like the nurses were just always coming by to see, you know, not just to check my vitals, but you know, just to come by and see if I needed anything or if I wanted anything." Patients appreciated it when nurses "just hung out" with them, without having any task to accomplish.

Patients used common interests to connect with nurses. Sometimes these relationships were used as an attempt to equalize power and decrease vulnerability. Some patients tried desperately to identify with nurses, as opposed to other patients, so that they would be treated as "special"—not "like other really sick patients." One participant described how she used the fact that she was a fellow employee to connect with her nurses during a hospitalization in a large healthcare system "that almost gives you a sense of family; they always treat you better because you are a family member. You know you are part of the tribe or you are part of the community, you know, so I thought I was getting perks that I bet not every patient up there was getting." Other patients tried to "make friends" with the nurses, which decreased their feelings of isolation.

In addition to "making friends," patients managed their relationships with nurses by following these simple rules: "Do what they tell you" and "Try to be a good patient." One participant said, "You are better off if you get along with them." Another participant described negative consequences for "not getting along with them." She said, "you have to be reasonable with them you know, it's just like a waitress in a restaurant; you piss her off, and she'll be liable to go back there and spit in your food, you know? ... Well you know, when you've pissed a nurse off, you know what? She's liable to make you wait that much longer."

Patients also described disconnecting aspects of relationships with nurses and other healthcare providers that contributed to displeasure and dissatisfaction with the acute care environment. Negative relational descriptors included nurses and other healthcare providers who were "not so friendly," "not so kind," "not so gentle," "think they are God," "less attentive," "did not understand," and "don't care." For example one participant said, "I had some unfriendly nursing staff, some inattentive nursing staff. And I was in for a kidney stone, so I was in quite a lot of pain." Another participant described nurses who did not seem to care: "Some of it was attitude, and some of them nurses just don't care. They just didn't care because it wasn't them. Like the one with the IV—my hand was hurting so bad, and like I said, it was swoll [sic], and she came in and I told her, I said, 'you can take it out.' She said, 'I can't take it out yet.'" Another participant, "overall that particular group of nurses was not that helpful, not that friendly."

Participants described nurses and other healthcare providers who "don't listen," "did not want to help," "ignored needs," and "acted angry, pissed, and frustrated." Dependency, vulnerability, and the belief that nurses are too busy are evident in the words of these participants: "You just need to take care of yourself because they ... are so busy doing paperwork," "Yeah, they take good care of you, but they ain't, how would I say that? They aint meetin' your social needs and your mental needs," and "Twenty to thirty minutes of time lapsed between the time I pressed the buzzer till the time the nurse arrived. I was basically incapacitated, you know, and on a lot of pain medication. [I] had to ask to be bathed, had to ask several times for juice and water." Another participant related the lack of connection with nursing staff to shorter stays: "And the nurses do not have, maybe it's the time, maybe it's the inclination, to have that kind of caring. In addition, it takes time to build up that kind of a relationship. When you come in after anesthesia on Wednesday and go home Saturday morning, there is not time to build up that kind of a relationship."

There were times during hospitalizations that extremely offensive comments were made to patients by healthcare providers. A 27-year-old gay man who was hospitalized for the surgical removal of a venereal "growth" reported one example. The healthcare worker who escorted the patient to surgery asked the patient what type of surgery he was having. The patient, who did not want to reveal his planned, very personal, surgical procedure, responded that he was having hemorrhoid surgery. According to the participant, "I was saying that it was hemorrhoid surgery and the guy that wheeled me to the anesthesia place said, 'How does a 20-something year old have hemorrhoids?'" An other participant, who was advised by her physician to go to the emergency room for direct admission to the hospital, said this of her experience: "The triage nurse was very rude. He had been rude to me before. I had been through that same ER less than 3 months before ... he told me that he knew I was a nursing instructor and he said, 'You don't get treated any differently from anybody else. You go and sit, and you sit until I'm ready for you.'" The following quotation illustrates a participant's conflictual relationship with a nurse:

There were some problems with my stent. And that was frustrating and painful for me and the doctor was real irritated and I remember them trying to get the stent out; they were having problems, and the nurse saying, 'Well, he keeps turning his IV machine off or I'm turning it on.' And I said, 'That's because you don't come when I press the buzzer.' She was standing there with the doctor and she was just, had a really negative, bad attitude. And I just, I was not very pleasant when I said that. But they seemed either very miserable with their work or just very burned out, or perhaps overworked. But it was not conducive to me getting well.

FEAR/LESS FEAR: Patients in the acute care environment experience fear due to vulnerability, health/illness/disability, and powerlessness. Fear is evident in the words of this participant, "I asked to see a chaplain because, it was a very sudden admission for me, very unexpected, and I knew that ... my life ... and well-being were very threatened, and I wanted to talk to someone in a spiritual sense." Participants described feeling "scared and alone," "at risk," "insecure," and "out of control." One patient describing her feelings pre-operatively, "I was scared ... I was scared going into that surgery." Patients appreciate reassurance and feeling like they are protected. Connections to others (nurses, family, friends, and others in the outside world) mitigate this fear by providing reassurance and protection. Attentiveness of these others (family, nurses, and physicians) increased feelings of safety and security. One participant described her "obsession" with staying connected as follows:

I just don't like being that dependent. I wanted to be sure that I could summon someone if I needed another person quickly enough ... I was obsessive with keeping it [call light] where I could reach it because they were good about answering that ... they always did. It wasn't always a nurse, but it was a voice, and it was someone who knew that I needed something. And the people on the other end of that, a unit secretary-type person, was extremely courteous.

Although patients in the acute care hospital experience fear, there are many aspects of that same environment that diminish this fear. When nurses are within close proximity ("they were right there"), as in the Intensive Care Unit (ICU) and recovery room, fear is decreased. When nurses "just check-in," patients also report feeling more secure, less fearful, less alone, and less afraid. Patients believe that "checking on me" is a sign that nurses "were on top of everything." One participant described the thoughtful actions of an ICU nurse with regard to a scary procedure as follows:

Going back to ICU, I made numerous trips for MRIs and so forth. I think I had either 3 or 4 preop, and a registered nurse went and stood beside me throughout the procedure for every one and almost insisted, and I'm glad she did, that I take some medication by about the third one, to settle me down a little bit because it was frightening. And she stood right outside, I mean I could see her. I could see my feet out there, and I could see my nurse, and she was right there. And sometimes she would tap me and say, 'It's okay' and it was really nice. And she herself escorted me from the unit to MRI and back to the unit, one on one ... her presence, I knew that she knew how I felt and I thought that she would be my advocate. That she would pick up if some sort of immediate intervention were needed. It was a real security blanket ... it was continuity. She knew all about me ... She was my nurse; she was the one who suggested that she give me a sedative before the third one. She communicated things for me.

Nurses' physical presence was not the only aspect of nursing that was comforting to fearful patients. Patients described a protective function that nurses performed against physicians' and others' errors: "The nurses was in there, and back then they had a head nurse in there. Buddy, she make all them doctors and nurses walk the line." Another participant said, "You know they [the nurses] are conscientious enough to go, hey, you know we are not always getting from the pharmacy what we need to, and this is not always the right stuff, and you know, and they didn't hesitate. If they couldn't read his writing, they'd page him you know." This participant summed up this protective aspect of a nursing presence: "Yeah, I felt like, you know, the doctors might screw me up, but the nurses would catch it if they did."

In addition to having staff nearby, many patients reported the need to have family with them throughout their hospitalization. One participant said, "My mom has always stayed with me through all the surgeries—every time I've been in the hospital." Another participant said, "You just feel a little more secure, a little safer when you have a family member or a friend right there with you. Looking out ... just to be there—just for you mentally or emotionally." And, "in my family, if somebody's in the hospital, somebody stays with them." One participant made clear that family members' presence afforded a special sense of protection as in the following:

If you're all alone and you don't know what's coming next, and you don't know when it's coming, that's frightening. It's just scary. And if you add on top of that, that you already know something is wrong because you're in the hospital and you've had surgery and you don't know the outcome of the surgery yet. That just compounds the scary. It compounds the frightening. And it just helps to have somebody there who you know cares about you. You know the nursing staff care about you in the abstract. But my children, my sister, my friends, colleagues, and peers care about me as Mary Smith, rather than caring about me as a 62-year-old woman who had hemicolectomy for colon cancer in room whatever I was in.

CONFINEMENT/FREEDOM: Study participants experienced the acute care hospital environment as confining: a place where they did not want to go, did not want to be, and were always glad to leave. The hospital environment was portrayed as "a necessary evil." Participants said they were "ready to go home ... more than anything else" and "ready to leave—just get out of the hospital." Other participants expressed confinement in this way: "I was obviously sick and needed to be there, but I kept thinking about wanting to go home, be out of the hospital." The powerlessness, induced by the environment along with the disconnection and fear that it provokes, contributes to the perception of confinement, as illustrated in the words of this participant: "I felt like I was under house arrest."

Participants used many words that illustrated the spatial orientation and corporeality of confinement. For example, "stuck there," "trapped," and "being tied down" were some words and phrases used by many participants. One participant had her greatest fears realized when she awoke in the ICU after brain surgery, "I remember my biggest fear was realized and that was waking up and still having that endotracheal tube in and not being able to talk or swallow and being tied down ... I was absolutely terrified ... it was just horrible." In addition to confinement via physical restraints, the patients' inability to talk isolates them from the interpersonal environment and, therefore, connection to others. This same participant later said the following:

I remember writing. I remember trying to tell them I wanted to write, and they said, "Don't pull the tube out." I wanted to slap their faces ... I'm not trying to pull the tube out but I have to talk and I can't talk. And I remember writing "choking" and they couldn't read it, and I tried again, and I couldn't read it ... I finally remember writing it and someone being able to say, "choking?" And I think I just looked exasperated and the next thing I remember, it may have been hours later, but I just remember the tube sliding out and I thought, 'Thank you, Jesus.' They untied my arms and I knew everything was going to be okay.

Confinement/freedom was also expressed in spatial terms that relate to the previously described themes connection/disconnection and fear/less fear. Terms such as open/closed door and private room versus double/shared room were important in descriptions of the hospital environment. The balance between privacy and connection can be found in words of participants who talked about the benefits and costs of privacy, connection, and fear. Participants appreciated the privacy that a private room and closed door provided; however, this seemed to be dependent upon level of mobility and ability to speak. For example, patients who were ambulatory seemed to appreciate a private room and closed door more so than people who were non-ambulatory and not able to speak. The higher the perceived vulnerability, fear, and disconnection, the more likely the participant would forgo "privacy" for the security of having someone "nearby in case I need them." Patients who were disconnected from the interpersonal environment by the inability to speak, such as the participant above who woke up in the ICU restrained and intubated, felt increasingly confined and at greater risk (ie, experiencing more fear).

Some aspects of the hospital environment were experienced as providing a sense of freedom. Patients who described experiences in the ICU felt paradoxically more free/less confined even though they were sicker, hooked up to more machines, less/not mobile, and unable to speak. This possibly relates to the nursing "being right there" and therefore decreasing overall patient fear and disconnection. On medical-surgical units, participants said "wide open spaces are good ... wide halls," and they spoke approvingly of units that had "big loops to walk around," which provided a perception of increased freedom. Other freeing aspects of the environment include "nurses just checking-in" and the patients' relationships with nurses. The relationships that patients had with staff allowed patients more freedom (eg, allowed to leave the unit).

Discussion

This study sought to describe the medical-surgical patient's experience of the acute care hospital environment. Three themes dominated study participants' perceptions of the hospital environment: (1) disconnection/connection, (2) fear/less fear, and (3) confinement/freedom. These themes are interdependent and interconnected. For example, attempting to connect with a nurse may decrease fear and increase perceived freedom. Patients want interpersonal connections with nurses who are friendly, who "check-in" frequently, and who are responsive. Some patients seek to be "good patients" and to "make friends with the nurses," which is consistent with findings from Shattell.¹⁶ These interpersonal connections with others help decrease fear and feelings of confinement in the acute care environment. Study participants described many negative care experiences. However, they often minimized these concerns. In essence, the global quality of care outcome from the patient's perspective was survival of the hospitalization. Perceived quality of care was determined by the friendliness, attentiveness, and responsiveness of the nurses. Technical competence or skill levels were rarely mentioned.

The findings of this study are largely consistent with those of Shattell,¹⁰ most notably with respect to the fearful and confining aspects of hospitalization for medical-surgical patients, which are mitigated to some extent by connectedness with nurses and other caregivers. The present study, perhaps because there was a much larger sample, provided more exemplars of comforting and reassuring connectedness with nurses than were evident in the 2002 sample.¹⁰ Allusions to the possibility of death and the importance of physical proximity to nursing staff were evident in both studies. The commonality between the findings of the two studies suggests that phenomenological methodology has produced a reliable and replicable thematic structure from which nursing implications can be derived.

Similarities can be observed between the confinement/freedom theme of the present study and comments of hospitalized patients in a recent study by Radley and Taylor.¹⁷ In that study, patients photographed their hospital ward, their room, and other spaces and objects that they found salient. Subsequently, the researchers interviewed the patients about the meaning of their photographs. Some photographs aptly conveyed patients' sense of claustrophobia (ie, curtains around the bed) while others represented the potential for freedom (stairs as an escape route). As in Shattell's study,¹⁰ having a window view afforded the opportunity to temporarily escape the sights and sounds of the hospital and, in some cases, offered hope of leaving the hospital soon.

Implications for Nursing Practice

The acute and critical care environment, as described by patients, is disconnecting, fearful, and confining. Nurses practicing in these settings could benefit from the knowledge gained in this study. While the purpose of this study was not to examine quality of care or patient satisfaction, the findings strongly suggest that patients determine quality of care by their relationships with nurses. A direct relationship between positive connections with nurses (and some ancillary hospital staff) and positive experiences of hospitalization seems to emerge from this study. As one participant simply said, "The relationship makes the environment better."

Patients want friendly, attentive, and responsive nurses. They want nurses who listen to them and genuinely care about their needs. Interestingly, they do not expect or want lengthy conversations or interactions. Patients want brief but frequent contact because it decreases the fear and insecurity that the hospital environment produces. The regular presence of the nurse was paramount for creating security and comfort. The close

proximity of the ICU nurse made patients feel safer and less fearful in critical care settings. Again, it is the knowledge that a nurse is "nearby" that is beneficial to the patient's experience, not that the nurse is in constant contact. Similarly, having families or significant others present helped to decrease feelings of fear and isolation.

Nurses and other healthcare providers need to attend to patients' feelings of confinement. Even such seemingly small things, such as shutting a patient's door, should not be done without thinking about that particular patient's preference and the possible intrapsychic ramifications such as increased patient fear and isolation. Nurses can respond to their awareness of the interpersonal isolation in hospitals by developing, implementing, and evaluating interventions to increase connectedness that patients in this setting (and most likely others) want and need in order to decrease their fear and aloneness. Nurses and hospital systems could champion the presence of a patient's family member or friend since it clearly is supported by the findings presented here.

Advanced practice nurses (APNs) in acute and critical care are in a unique position to affect patients' experiences of the hospital environment. APNs are expert clinicians, educators, researchers, managers, and administrators and, therefore, are in ideal positions to evaluate and implement change to improve the quality of care of hospitalized patients. Whether caring for patients at the bedside, orienting new nurses or educating senior nurses, role modeling appropriate high quality care, developing and implementing research most germane to patient care and health outcomes, managing a nursing care unit or ICU, supporting the bedside nurse, designing quality improvement studies, tracking patient satisfaction surveys and results, or implementing new care delivery models (such as the AACN's Synergy Model),¹⁸ APNs can have a far reaching affect on hospital environments as patients perceive it.

Conclusion

The purpose of this study was to describe the patient's experience of the hospital environment. In so doing, we found that patients were not concerned with the physical environment. Interpersonal factors such as disconnection/connection and fear/less fear were dominant in their descriptions, as well as the spatial aspects of the experience of the hospital setting, confinement/freedom. These research findings suggest that the focus on healing environments needs to be primarily focused on interpersonal care, not on the physical environment such as the color of walls or architectural design. The Synergy Model¹⁸ is one care delivery system that addresses the healing environment from this perspective.

Another method of creating a more peaceful and healing environment in some ICUs is the implementation of quiet time. Even though outcomes have been considered favorable, the nurses analyzing the effectiveness of the procedure noted the difficulties encountered by the routines of other professionals, including fellow nurses.^{19,20} APNs could assist the ICU staff nurse in coordinating quiet time with immediate care needs. Other facilities have done tremendous work on improving their architecture and physical surroundings, adding features that provide visual appeal, such as murals and "healing gardens."²¹ Attention to these physical aspects of the environment, while potentially aesthetically comforting, would seem less important than altering the interpersonal aspects of the environment, which is clearly desired by patients in this study.

The hospital environment is perceived by patients as a network of relationships. In an environment that produces feelings of fear and confinement, patients focus on their relationships with nurses—the people upon whom they depend to mediate this stressful environment. Few people in the study spoke of the actual physical environment of the acute care hospital. The following words of a study participant serve as a reminder to all practicing nurses that they make a vital difference: "The psychic income from being a nurse is having that personal reward for knowing you're making a personal difference to someone in that human-to-human contact."

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