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Exploratory Study of Nurse-Patient Encounters in Home Healthcare: A Dissertation

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Exploratory Study of Nurse-Patient Encounters in Home Healthcare

A Dissertation Presented

by

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Exploratory Study of Nurse Patient Encounters in Home Healthcare

A Dissertation Presented

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28 April 2016
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ABSTRACT

The purpose of this study was to explore nurse-patient encounters from the perspective of the Home Healthcare Registered Nurse. A qualitative descriptive design was used to collect data from a purposive sample of 20 home healthcare registered nurses from Connecticut, Massachusetts, and Rhode Island currently or previously employed as a home healthcare nurse. Four themes and one interconnecting theme emerged from the data: *Objective Language*; *Navigating the Unknown*; *Mitigating Risk*; *Looking for Reciprocality in the Encounter*; and the interconnecting theme of *Acknowledging Not All Nurse-Patient Encounters Go Well*. One goal of the study was to propose an empirically informed definition of what constituted a difficult encounter. An important early finding was that the terms *difficult patient* and *difficult encounter* were not generally used by study participants. HHC RNs voiced a preference for objective and nonjudgmental language to communicate outcomes of nurse-patient encounters. Three types of HHC RN-patient interactions emerged from the data, with constructive encounters the norm and non-constructive or destructive encounters less frequent. A *constructive encounter* is when two or more human beings, the nurse on the one side, and the patient, caregiver, or both on the other, interact to achieve a mutually agreed upon outcome. A *non-constructive encounter* is when one or more human beings obstruct efforts to achieve at least one positive outcome. A *destructive encounter* is when one or more human beings direct anger at or physically aggress toward another human being. Strategies to promote reciprocality are routinely employed during HHC RN-patient encounters, but HHC RNs who miss cues that a strategy is ineffective or failed may be at risk in the home. Study data lend support to key concepts, assumptions, and propositions of Travelbee's (1971)

Human-to-Human Relationship Model. Study results provide a foundation for further research to increase the understanding, recognition, and development of empirically derived responses to non-constructive or destructive encounters such that HHC RNs are safe and best able to meet patients' healthcare needs.

DISSERTATION PROPOSAL

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Graduate School of Nursing

University of Massachusetts Worcester

CHAPTER 1

STATE OF THE SCIENCE

Introduction

The healthcare literature is limited in explaining the characteristics and context of difficult patient encounters. No studies have been found that explore difficult encounters between home healthcare registered nurses (HHC RNs) and patients. The term *home healthcare* (HHC) is used to describe hospital level of care delivered to individuals in their home by professionals such as RNs with the objective of maintaining or enhancing the individual's quality of life and functional status. Preventive, acute, rehabilitative, chronic, and end-of-life services are available to individuals from the very young to the very old (Thome, Dykes, & Hallberg, 2003). It can be anticipated as providers, insurers, and consumers attempt to contain costs in response to changes in healthcare benefits, more patients will be receiving healthcare in the home setting. Unlike in a hospital or outpatient healthcare setting, HHC RNs do not have on-site support of other nurses, support staff, administration, or security. Prompt recognition by the HHC RN of cues that a patient encounter is turning difficult is critical to ensuring nurse and patient safety.

This chapter will provide the background of what is known about difficult patient encounters, concluding with the identification of inconsistencies and aspects of this concept that are not well explained or understood. The literature review shaped the design of a proposed qualitative descriptive (QD) study to explore difficult nurse-patient encounters from the perspective of HHC RNs. The specific aims of the study are to propose an empirically informed definition of what constitutes a difficult encounter, to identify cues or common characteristics HHC RNs associate with an encounter turning

difficult, to describe how HHC RNs respond to difficult encounters, and to elucidate the strategies used to establish a human-to-human relationship or rapport. The outcomes of this study will provide a foundation for future research to empirically test strategies and interventions that may prevent or mitigate difficult encounters in HHC and other practice settings. It is imperative HHC RNs are knowledgeable, skilled, and educated in the use of research-based strategies to respond to difficult patient encounters in the home.

Literature Review

This literature review was conducted to synthesize the theoretical and empirical literature relevant to understanding difficult patient encounters from the perspective of the HHC RN. Garrand (2011), Ganong (1987), and Whittemore and Knafl (2005) were referenced for guidance and formatting of this review. The identification of gaps in the literature on difficult encounters substantiates additional exploration of difficult encounters between the patient and HHC RN.

Research Questions

What makes a nurse-patient encounter in the home difficult?

Are there cues that HHC RNs associate with an encounter turning difficult?

Is there anything HHC RNs do to prevent or mitigate difficult encounters?

Guiding Theoretical Framework for Literature Review

Difficult encounters between nurses and patients or patient companions has not been fully examined in the literature. Difficult patients and encounters were studied intently during the late 1960s to the early 1990s (Gerrard & Riddell, 1988; Groves 1978; Hahn et al., 1996; Hahn, Thompson, Wills, Stern, & Budner, 1994; O'Dowd, 1988; Peterson, 1967), with a resurgence in early 2000 (An et al., 2009; An et al., 2013;

Demarco, Nogueira-Martins, & Yazigi, 2005; Finlay, 2005; Hinchey & Jackson, 2010; Kroenke, 2009; Lorenzetti, Mitch Jacques, Donovan, Cottrell, & Buck, 2013; Macdonald, 2007a, 2007b; Sellers et al., 2012; Steinmetz & Tabenkin, 2001). Research efforts were directed toward gaining insight into the characteristics of the encounter itself versus defining the concept. Morse, Mitcham, Hupcey, and Tason (1996) defined a mature concept as being "well defined, has clearly described characteristics, delineated boundaries and documented preconditions and outcomes" (p. 387). A formal definition of a difficult encounter could not be located, suggesting the concept is immature. Further research is warranted to formally define the concept, study the dynamics of initial encounters and identify behaviors that lead to difficult encounters. Travelbee's (1971) Human-to-Human Relationship Model was selected to lend guidance, direction, and structure to this review of the literature. Language threaded throughout Travelbee's writings influenced the selection of key search terms and the in-depth review of retrieved articles (Travelbee, 1963, 1964, 1971).

Method

An electronic literature search of Pub Med, Journals@Ovid, PsycINFO, CINAHL, Cochrane Data Base, Google ™ Scholar (Beta), and NursingPlus.com was conducted using the search terms "home healthcare and difficult encounters," "nurse and difficult encounters," "difficult encounters," "nurse and encounters," "encounter," "difficult patient encounters," "difficult patient relationships, "difficult patients," "difficult interactions," and "interactions and nursing." In response to terms identified in the literature, the key search term "encounter" was broadened to include the search term "interaction." The key search terms "violence and home healthcare nurses" and "violence

and nursing" were incorporated into the search after initial electronic searches and article reference lists yielded limited articles with a HHC focus. The primary search limitation was English language. There were no date limitations.

Journal articles with one or more of the search terms included in the title were retained for first-pass review. A repeat electronic search in Pub Med, Journals@Ovid, CINAHL, and Google ™ Scholar (Beta) with date limitations narrowed to 2007–2013 was completed to ensure all relevant publications in the past 6 years were captured. The same key search terms used in the initial search plus the search term "reciprocity" were included. The key search term "reciprocity" was derived from the assumptions that the nurse-patient relationship and communication between the nurse and patient are reciprocal processes (Travelbee, 1971). Repeat searches of PsycINFO, Cochrane Data Base, and NursingPlus.com were not conducted because minimal relevant citations were generated during the initial search.

A multistep approach was used to organize references for in-depth review. Abstracts or articles not available electronically or through interlibrary loan were excluded. First-pass review involved scanning abstracts and articles without abstracts for key search terms. Abstracts and articles that included search terms in the text but were not pertinent to understanding the concepts of "encounters" or "difficult encounters" were eliminated. Article reference lists were reviewed to identify leading research scholars and seminal works. Retrieved articles were organized according to the Matrix Method as described by Garrard (2011). Articles were filed into electronic folders by database and within each database folder by key search terms. First-pass-reviewed articles were moved to electronic folders based on the primary purpose of the article.

Inclusion Criteria.

Published in English language

Theoretical literature proposing definitions of difficult patient or patient

characteristics associated with difficult encounters

Qualitative or quantitative research investigating difficult patients, difficult

encounters, violent encounters, and reciprocal relationships

Articles on instruments relevant to measuring the characteristics or predictors

of difficult patients, providers, or encounters

Articles including concepts relevant to the understanding the human-to-

human relationship as proposed by Travelbee (1971) such as original

encounter, emerging identities, empathy, sympathy, rapport, reciprocal

relationship, communication, and dehumanization

Exclusion Criteria.

Language other than English

Not available electronically or in hard copy from university library or

interlibrary loan

Unpublished manuscripts or dissertations

One book and a total of 69 articles met the inclusion criteria. The in-depth review

included a minimum of two readings of the reference or article. A review matrix table

(Garrand, 2011) was created using Word®. The first line of each section had a broad

category such as difficult encounter, difficult patients, violence, and reciprocity. Directly

under each broad category, articles were classified according to purpose such as nursing

research, medical research, nursing review, medical review, nursing opinion, medical

opinion, theory, and non-nursing. Beneath each broad category and article classification were five columns: Source [Author/Title/Journal], Purpose, Method [Sample], Findings, and Implications.

Definition of Difficult Encounter

The term *difficult encounter* has been used in literature reviews (Arciniegas & Beresford, 2010; Breuner, & Moreno, 2011; Lorenzetti et al., 2013), in studies that examined the origins or characteristics of difficult physician-patient interactions (An et al., 2009; An et al., 2013; Elder, Ricer, & Tobias, 2006; Hahn et al., 1994; Hahn et al., 1996; Hinchey, & Jackson, 2010; Jackson & Kroenke, 1999; Macdonald, 2007a, 2007b; Sellers et al., 2012), and in articles that explored the discourse surrounding such encounters (Demarco et al., 2005; Evans, 2009; Hull & Broquet, 2007; Kroenke, 2009; Kron, Fetters, & Goldman, 2003; Spriggs, 2011), without a consistent or standard definition of what a difficult encounter actually is. No research-derived, evidence-based, or even expert-consensus definition of a difficult encounter was found. While there is limited specific research on difficult encounters, there is more research that has led to definitions and descriptions of difficult patients. The literature on difficult patients is included in this review because specific patient characteristics have been associated with difficult encounters in select practice settings and the content is pertinent to our understanding of difficult encounters between the patient and the HHC RN. In this chapter, the term *difficult encounter* will refer to interactions between a provider and patient that is perceived by the provider as challenging, not reciprocal, that interfered with, interrupted, and delayed the delivery of care.

Characteristics and Definitions of Difficult Patients

Difficult patients have been characterized and labeled in the literature since the late 1960s. Peterson (1967) proposed that the difficult patient is someone whose emotional, physical, or emotional and physical needs are not met. Groves (1978) used labels such as "dependent clingers, entitled demanders, manipulative help-rejecters, and self-destructive deniers" to categorize what he termed "hateful patients" (Groves, 1978, p. 883). Other labels to describe difficult patients have included "heartsink" (O'Dowd, 1988, p. 528), "blackholes" (Gerrard & Riddell, 1988, p. 530), and "bothersome" (Evans, 2009, p. 1340).

Patients with an underlying psychiatric diagnosis, alcohol abuse, substance abuse, or a combination of one or more, are frequently labeled as difficult (Hahn et al., 1994; Hahn et al., 1996; Laskowski, 2001; Sellers et al., 2012). When compared to non-difficult patients, a significantly higher percentage of difficult patients have been reported by Hahn et al. (1996) to have at least one psychiatric diagnosis (67% versus 35%, $p < .0001$). Those researchers revealed that approximately one third of patients ($N = 627$) were perceived by primary care physicians ($N = 27$) as difficult to communicate with and self-destructive. Multisomatoform disorder ($p < .001$), probable alcohol abuse or dependence ($p < .001$), and panic disorder ($p = .052$) remained independently associated with physician perception of a difficult experience after adjustment by analysis of covariance (Hahn et al, 1996). These findings expanded upon an earlier description of the "typical difficult patient" as having "three to four psychosomatic complaints and mild to moderate depression, all embedded in a moderately abrasive personality" (Hahn et al., 1994, p. 655).

Koekkoek, van Meijel, and Hutschemaekers (2006) conducted an electronic search of the mental health literature published 1979–2004 in Medline, PsychInfo, and CINAHL to define the characteristics of difficult patients, explore how the difficult patient has been explained, and to identify effective treatment strategies. The key search terms "difficult patients" or "problem patient" combined with assorted psychiatric terms yielded a final sample of 94 articles. Four articles with earlier publication dates were included because the articles were frequently cited and were considered seminal works. Non-mental health, diagnosis-specific, and reflective or theory-building articles were excluded. Koekkoek and colleagues (2006) concluded there was consensus in the literature regarding the characteristics and behaviors of difficult patients. Difficult patients could be categorized into three subgroups: (a) "unwilling care avoiders," (b) "demanding care claimers," and (c) "ambivalent care seekers" (Koekkoek, van Meijel, & Hutschemaekers, 2006, p. 796). The mental health nursing literature focused on situations with difficult patients that resulted in labeling or exclusion. Literature that explained why some patients are difficult was limited, and empirical evidence to support recommended interventions, particularly the management of ambivalent care seekers, was minimal.

Difficult Relationships Versus Difficult Patients

In the last 12 years, interest has resurged on the topic of difficult patients and patient encounters that are perceived by providers as difficult. A concept analysis of the difficult patient using Walker and Avant's method led Macdonald (2003), a nurse researcher, to define the difficult patient as "a person who does not assume the patient role expected by the healthcare professional, who may have beliefs and values or other personal characteristics that differ from those of the caregiver, and who causes the

caregiver to experience self-doubt" (Section 1, paragraph 6). The definition of a difficult patient as "a problem of relationship, one in which the patient and physician fail to reach mutual understanding at one of a variety of levels," (Anstett, 1980, p. 286) has regained momentum in medicine. The recent literature supports moving beyond the study of difficult patients and provider characteristics to exploring what occurs during the provider-patient interaction that the outcome is a difficult encounter (Demarco et al., 2005; Hinchey & Jackson, 2010; Kroenke, 2009; Lorenzetti et al., 2013; Macdonald, 2007b; Sellers et al., 2012).

Sellers and colleagues (2012) concluded they did not "believe that patients themselves are difficult, but interactions can be" (p. 674). They proposed "internal and external factors both contribute to negative (and positive) feelings when working with certain patients" (Sellers et al., 2012, p. 674). They further concluded that variables associated with difficulty should not be perceived as the source of the difficulty but instead as "markers to alert the physician of potential issues that may affect his or her desire to provide the best clinical care" (Sellers et al., p. 674). The early writing on difficult patients described characteristics of difficult patients and patient characteristics associated with difficult encounters (Hahn et al., 1994; Hahn et al., 1996; Jackson & Kroenke, 1999). More recent work suggested how the provider interacted with the difficult or non-difficult patient influenced whether the outcome of the encounter was negative or positive (Elder et al., 2009; Hinchey & Jackson, 2010; Lorenzetti et al., 2013; Steinmetz & Tabenkin 2001). The specific factors of the patient-provider interaction that may trigger or alleviate difficult encounters have yet to be clearly identified.

Difficult Encounters Between the Nurse and Patient

Research of difficult encounters in nursing, specifically between nurses and patients (MacDonald, 2007b), has been limited. The key search terms of "home healthcare and difficult encounters," "nurse and difficult encounters," "difficult encounters," "nurse and encounters," "encounter," "difficult patient encounters," "difficult patient relationships," "difficult patients," "difficult interactions," and "interactions and nursing" generated only four nursing studies whose purpose was to either study difficult patients (n = 1), nurse-patient interactions in HHC (n = 1), difficult communication (n = 1), or difficult encounters between nurses and patients (n = 1). The electronic literature search did not generate any articles or studies on difficult encounters in HHC (n = 0).

Podrasky and Sexton (1988) used an exploratory survey design with hypothetical nurse-patient encounters to isolate patient characteristics and nurse response to behaviors associated with difficult encounters (N = 73). They developed the Difficult Patient Assessment Tool (DPAT) based upon the literature, the nurse researcher's personal nursing experience, and the experiences of other nurses. The DPAT consisted of a biographic data form, Vignette Reaction Inventory Form, Nurse's Response Profile, and the Unpopular Behaviors Checklist. Content validity was completed but no measures of reliability were conducted. Uncertainty of the degree of instrument reliability was a limitation of the study, but findings were clinically significant to understanding difficult patients. Out of 69 terms on the Unpopular Behavior checklist, study participants most frequently selected demanding (n = 62), complaining (n = 46), frustrating (n = 45), time consuming (n = 43), requesting often (n = 42), calling frequently (n = 41), manipulative

(n = 40), female (n = 38), impolite (n = 38), unreasonable (n = 37), and uncooperative (n = 36) to describe difficult patients. Many of these descriptors such as demanding, time consuming, and manipulative were consistent with findings from other studies (Elder et al., 2006; Gerrard & Riddell, 1988; Hahn et al., 1994; Naish et al., 2002). Podrasky and Sexton (1988) also reported frustration and anger as the most frequently experienced emotions associated with difficult encounters. Nurses were more apt to label patients as difficult if the nurse perceived the patient could control or modify the behavior. This finding was consistent with results from a later study by May and Grubbs (2002) retrieved after review of a reference list of an article on the abuse of hospital nurses. Hospital-based nurses also reported being less tolerant of patients with no underlying pathology than patients perceived to not be in control of their behavior (May & Grubbs, 2002).

Spiers (2002) used a qualitative ethologic video-based approach to explore factors influential in negotiating patient care and outcomes in the HHC setting. No study limitations were identified by the authors but videotaping the nurse-patient interactions may have influenced the context of the encounters. The home visits (n = 31) of three HHC RNs and eight patients for a total of 10 nurse-patient dyads were analyzed. The analysis generated what Spiers (2002) described as six interpersonal contexts: (a) negotiation of territory, (b) negotiation of shared perceptions of the situation, (c) establishment of an amicable working relationship, (d) synchronized role expectations, (e) negotiation of knowledge, and (f) sensitivity to taboo topics. Spiers observed encounters that she perceived as difficult, not reciprocal, and at times threatening but reported only her interpretation of the HHC RN response to the patient behavior. She did

not include the HHC RNs' perspectives or descriptions of the encounters she observed or the case she included for negative, comparative sampling. Spiers recommended further research to examine nurse sensitivity to patient cues and skill level in real-time negotiating.

Kennedy Sheldon, Barrett, & Ellington (2006) used a grounded theory approach to explore and define difficult communication from the perspective of nurses. Findings were more reflective of a study on difficult encounters than difficult communication. Data were collected from six focus groups. A follow-up questionnaire was distributed to all participants (N = 30) to validate 13 identified categories of difficult communication using Likert-type scale categories. Response rate was 18 of 30. The five themes that emerged from the focus groups were (a) specific diagnoses and clinical situations, (b) patient and family emotions, (c) nurse emotions, (d) nurse coping behaviors, and (e) triangle of nurse-physician-patient communication. Kennedy Sheldon and colleagues (2006) did not propose a clear, succinct definition of difficult communication but the core variable identified as contributing to difficult communication was negative emotions. The finding of negative emotions was consistent with results from other studies examining difficult patient encounters (Elder et al., 2006; Podrasky & Sexton, 1988).

Only one nursing study (Macdonald, 2007b) explored the origins and context of difficult encounters from the perspective of nurses and patients. The setting was a Canadian hospital adult medical unit. Macdonald (2007b) used a constructivist grounded theory approach to collect data from a small sample of female nurses (N = 10) and patients (N = 12) during 120 hours of participant observations and interviews over a 10-month period. In contrast to studies by others that focused on the characteristics of

difficult patients or providers, the specific aims of this study were to explain the context of the nurse-patient encounter (Macdonald, 2007b). The core category identified was reconciling temporalities (time). Time was a primary concern of nurses and patients in relation to the nurse having sufficient time to provide patient care and develop a relationship with the patient. Macdonald (2007b) concluded there was a relationship between the length of time a nurse and patient knew each other and the effort needed to reconcile a difficult encounter. Other factors such as presence of family members, access to supplies, co-workers, design of the work area, the reputation of a unit, and staffing patterns were identified as contributing to or minimizing the potential of difficult encounters.

Incidence of Difficult Encounters in Healthcare Settings

The incidence of difficult encounters in primary care and mental health settings has been reported. In Hahn and colleagues' (1996) study, primary care physicians reported one out of six patient encounters (15%) as difficult. Three other studies with primary care physicians had similar findings, with incidence of difficult encounters ranging from 10% to 20% (Hahn et al., 1994; Hinchey & Jackson, 2010; Jackson & Kroenke, 1999). Similarly, in a cross-sectional study of psychiatrists (N = 20), participants rated 15% of patient encounters as difficult (Sellers et al., 2012). Stein, Frankel, and Krupat (2005) conducted a longitudinal case study of The Permanente Medical Group (TPMG) physicians (N = 5,300) to examine the effectiveness of the Kaiser Permanente Thrive Program. Half of survey respondents reported one out of every 10 visits as frustrating pre-Thrive Program (Stein et al., 2005).

A higher incidence of difficult encounters is reported in an Israeli study of primary care physicians conducted by Weingarten and colleagues (2010). They collected data from seven focus groups (N = 57) and videotapes of 291 physician-patient encounters (N = 291) to explore the incidence and types of physician-patient conflicts and report that conflict was identified in 113 (38.8%) of physician-patient encounters. Conflict was defined for the purpose of the study as "as any disagreement (expression of a difference of opinion) by the patient or doctor" (Weingarten et al., 2010, p. 95). The use of the term *conflictual encounter* in this study instead of *difficult encounter* demonstrates the inconsistency and variation in language used to describe provider-patient interactions and relationships.

In contrast to the medical literature, nursing has not reported incidences of difficult encounters between nurses and patients. However, nursing literature documenting an increasing incidence of violence against nurses in a variety of practice settings is considerable, as described in the next section. The literature on nurse exposure to violence is included in this review because the boundaries between difficult and violent encounters in healthcare have not been clearly delineated. As well, without a standard definition of what constitutes a difficult encounter, it is reasonable to consider RN exposure to violence from patients or patient companions a difficult encounter.

Nurse Exposure to Violence in Healthcare Settings

Jackson, Clare, and Mannix (2002) surveyed health management journals on the topic of workplace violence in nursing 1995–2000. They concluded there was a gap in the nursing research documenting the incidence and impact of violence against nurses despite studies demonstrating a relationship between impaired work performance,

anxiety, sleep disorders, and post-traumatic stress disorder as a consequence of hostility and violence in the workplace. In 2007, violence against nurses was recognized as one of the three top priorities confronting the nursing profession (National Advisory Council on Nurse Education and Practice [NACNEP], 2007). Nurses were identified as "among the most assaulted workers in the American workforce" (NACNEP, 2007, p. 2) with patients reported as the leading perpetrators of violence against nurses (Jackson et al., 2002). Nurse recognition and response to a potential or actual violent encounter is a critical skill for nurses in all settings, but particularly in HHC. In HHC, it is the norm for nurses to be alone in a home without direct contact with other personnel.

In response to the rapid growth in HHC and the void in organizational preparation of nurses potentially practicing in unsafe home environments, Grindlay, Santamaria, and Kitt (2000) conducted one of the earliest studies to examine actual and perceived risks reported by Australia Victorian Hospital in the Home Health (AVHITH) nurses. A cross-sectional pilot study of randomly selected AVHITH nurses (N = 50) was conducted in 1998. The sample represented 17.5% of AVHITH nurses. Researchers reported a 70% response rate with 35 nurses of the initial sample of 50 participating in the study. More than half of respondents (54.3%) reported a sense of threat during their work as an AVHITH nurse. Respondents reported feeling threatened by the unknown and environment (31.4%), being out at dark (22.9%), and by patients, family members, or other residents (22.9%). The mean score for perception of threat on a 100 mm visual analog scale (VAS) with anchor points of no threat and greatest threat was 6.85. Statistical analysis with SPSS 8 did not show a significant correlation between VAS perception scores and years of nursing experience (r = 0.02; p = 0.45), years of home care

nursing (r = 0.10; p = 0.45), or years providing AVHITH nursing care (0.15; p = 0.18).

Twenty-eight percent of the situations that the nurse respondents considered potential

incidents were felt by the researchers to be actual incidents. Grindlay and colleagues

(2000) concluded there was no relationship between the demographics of the AVHITH

nurse and perception of threat. The research by Grindlay et al. (2000) is dated, but their

findings are relevant to our attempt to recognize and understand difficult encounters.

In an American study by Canton and colleagues (2009), 63% of study respondents

(n = 465) reported one or more violent exposures, and 19% reported two or more

exposures (n = 140). Researchers measured "a history of exposure to workplace

violence" as one or more HHC RN self-reported experiences of "verbal abuse, threat of

physical harm, actual physical assault, or threat of theft/damage to car" (Canton et al.,

2009, p. 366). In a more recent American study by McPhaul, Lipscomb, and Johnson

(2010), designed to test measures to assess risk of violence toward staff during home

visits, 80 out of 130 respondents (61.4%) reported being yelled at, shouted at, or sworn

at. Five (3.8%) respondents reported an assault requiring an emergency room or

physician evaluation in the past 12 months. Twenty-one (16.2%) reported being

threatened without physical contact in the past month. Eight (6.5%) reported visiting

patients with a history of assault or violence at least monthly within the previous 12

months. Eighteen (15.4%) reported at least once a month before an initial visit they had

received information about a patient with a history of violent behavior. A larger number

of respondents reported at least once a month receiving information about a patient with a

history of mental illness (43.9 %) or substance abuse (41.5%). The sample (n = 78

nurses; n = 49 other—aides, speech therapists, physical therapists, and social workers or

social worker assistants; n = 3 no response) was not demographically diverse (20.8% non-white and 91.5% female), but respondents were older (43.8% 50 years or older), educated (88.5% college degree or higher), and experienced home healthcare clinicians (56.9 >10 years; McPhaul et al., 2010).

The differences between difficult and violent encounters in healthcare have not been clearly delineated. In most studies, verbal or physical abuse was reported as the first sign there was a problem in provider-patient encounter (Canton et al., 2009; Chambers, 1998; May & Grubbs 2002; McPhaul et al., 2010; Pejic, 2005). Crabbe, Alexander, Klein, Walker, and Sinclair (2002) conducted a study to describe the experiences and perspectives of nurses (N = 289) who worked in high-risk areas with aggressive and violent patients. Response rate was 54% (N = 156). This study differed from others in that researchers divided violent incidents into three categories: (a) verbal abuse, (b) threatened assault, and (c) violence. The researchers designed a self- administered questionnaire booklet that included a definition for each of the three categories. Verbal assault was defined as "harassment, threats or other unpleasantness that the respondent found damaging, and which was directed at them from a patient" (Crabbe et al., 2002, p. 122). Threatened assault was defined as "threatening or aggressive behaviour which the respondent found damaging and which was directed from a patient, but did not result in physical injury" (Crabbe et al., 2002, p.122). Violence was defined as an "incident in which the respondent was physically abused, assaulted or otherwise injured by a patient" (Crabbe et al., 2002, p. 122). In the 2 years previous, 70% of respondents reported they were victims of patient violence, and 90% experienced threat of physical assault or verbal

abuse. Only four respondents did not report any incidences of patient violence (Crabbe et al., 2002).

The NACNEP (2007) report documented a disturbing trend of nurses not reporting incidences of violence. Nurse reported verbal abuse less frequently than acts of physical abuse. Underreporting by nurses has been attributed to nurse perception that violence is part of the job, concerns employer may attribute incident to poor employee performance, potential litigation, desensitized to workplace violence, and caring for patients not cognizant of their behavior due to a medical condition. In the May and Grubb study (2002), nurses (N = 86 respondents) from the intensive care unit (n = 31.4% of respondents), emergency department (ED; n = 32.6% of respondents), and general floors (n = 36% of respondents) reported violence was perceived as part of the job (39.5% of total respondents) and reporting the incident would not make a difference (37.2% of total respondents). ED RNs reported the most frequent incidences of verbal assault (100%) and physical assault (82.1%) within 12 months. Physical assault of nurses by patients were most frequently associated with patients with a history of cognitive dysfunction (79.1%), substance abuse (60.5%), or anger with their situation or condition (55.8%). Anger directed at staff for enforcing hospital policies was identified by 58.1% of respondents as the most frequent reason for assault or abuse by family members or visitors. Respondents also reported incidences of anger stemmed from a patient's condition or situation (57%), long wait times (47.7%), and discontent with the healthcare system in general (46.5%). In this unit study, half (50%) of the respondents reported finding a weapon on a patient (May & Grubbs, 2002).

An increasing incidence of violence against nurses, desensitization of nurses to violence, and underreporting of violent incidents by nurses has been well documented. The NACNEP (2007) has recommended regulatory agencies develop a standard definition of workplace violence and institute measures to ensure workplace safety. At a minimum, it has been recommended that nurses should be taught to protect themselves if a patient encounter is perceived to be escalating toward a violent interaction (NACNEP, 2007). Prompt recognition of cues an encounter is turning violent or difficult is a critical skill for nurses in all practice settings but particularly for HHC RNs who practice outside the walls of traditional healthcare facilities.

The Health Resources and Services Administration (HRSA) projected a 109% increase in the demand for full-time equivalents of HHC RNs between 2000 and 2020 (Biviano et al., 2003). Significant correlations between exposure to workplace violence and job satisfaction (OR = 1.86; 95% CI = 1.28–2.70), turnover intention (OR = 1.95; 95% CI = 1.31–2.91), and exit intentions (OR = 1.53; 95% CI = 1.03–2.27) have been reported in the HHC literature (Canton et. al., 2009). Highly skilled and dedicated HHC RNs may opt for the secure setting of clinics or hospitals instead of the autonomous practice of HHC. This has serious implications for the HHC industry, the healthcare system, and, most importantly, the patients who receive HHC services. Recognizing that an encounter is turning difficult and knowing empirically tested strategies to mitigate or de-escalate an encounter are imperative to clinical practice in a HHC RN.

Variables Associated With Difficult Encounters

The research on difficult encounters between nurses and patients is limited, but there is relevant nursing, medical, and other industry literature exploring variables that

may be associated with outcome of an encounter. One-time patient encounters, poor

provider communication, and lack of reciprocity between patient and provider have been

associated with difficult encounters in nursing and medicine.

One-Time and Brief Encounters

One-time and brief encounters have been identified by nursing (Crawford &

Brown, 2011; Macdonald, 2007b) and mental health (Sellers et al., 2012) as having an

increased potential for difficult encounters. Manchon (2006) proposed that patients make

snap judgments based on the nurse's initial approach, attitude, grooming, touch, listening

ability, and knowledge. Her assumption was derived from 30 years of acute and

community nursing, education and certification as an advanced practice nurse, and her

personal experience in various healthcare settings as a patient with a 20-year history of

chronic illness. She proposed that nurses be attentive to their initial approach, which

included how the nurse walked, respect for the patient's personal space, how the nurse

addressed the patient, eye contact, and voice tone. Manchon did not empirically test her

recommendations, but her observations contribute to heightening nurse awareness of

potential variables that may influence the patient-nurse dyad and outcome of an

encounter.

Medical researchers examined the patient perspective of initial greetings by

medical students, residents, and physicians. Makoul, Zick, and Green (2007) conducted a

cross-sectional, random digit-dial, computer-assisted telephone survey. Calls were made

to 1,489 known active residential numbers. Videotapes of 600 patient encounters were

also analyzed. Response rate for the call survey was 28% (N = 415 surveys). More

patients (78.1 %) preferred physicians shake hands at initial greeting. At least 50.4% of

patients preferred the physician call the patient by their first name, and 23.6% preferred the use of both first and last name. Physicians introducing themselves by first and last name was preferred by 56.4% of patients. Makoul and colleagues (2007) concluded that the initial greeting is vital to creating positive first impression, establishing a therapeutic relationship, and building rapport.

Crawford and Brown (2011) reviewed the literature on brief communication and the potential for positive and negative outcomes depending on the quality of the brief physician-patient encounter. Four key ideas were proposed to promote positive brief communications to counter "task busy environments" (Crawford & Brown, 2011, p. 5). The four key ideas include the following: (a) emotional tone and display; (b) creating a sense of trust and respect in brief health encounters; (c) time tardises, the attention to quality instead of length of encounter, and indexicality, the shared understanding of words used within the context of the encounter; and (d) phatic communication, personal details, and small talk (Crawford & Brown, 2011). The authors proposed identifying effective strategies to shift patient focus from the length of physician encounter to the quality and outcomes of the encounter.

Poor Provider Communication

Communication, in particular how providers communicate, has been associated with difficult encounters. Travelbee (1971) defined communication as a "reciprocal process" and identified breakdowns in communication as a hindrance to establishing rapport, or what she labeled "a human-to-human relationship" (p. 94). Anstett (1980) concluded that difficulty in the physician-patient relationship included poor communication, lack of awareness of patient expectations in advance, not assessing

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patient coping skills, and not exploring the meaning of the illness to the patient. Content analysis of complaints (N = 105) received by the Sweden Patient Advisory Committee for care delivered at Swedish University Hospital determined insufficient information, disrespect, and lack of empathy were the three themes associated with negative encounters (Jangland, Gunningberg, & Carlsson, 2009). Spriggs (2011) used actual physician-patient scenarios including improperly attributing a negative outcome to the care of another physician to demonstrate how physician communication can complicate an encounter or exacerbate a difficult encounter.

McCabe (2004) explored nurse communication from the patient perspective. Data were collected from unstructured interviews from a purposive sample of eight patients. The themes that emerged from the data were lack of communication, attending, empathy, and friendly nurses. Results did not support findings from other studies that nurses were not effective communicators (McCabe, 2004; Spiers, 2002; Wiman & Wikblad, 2004). Instead, in this study, nurses who used a patient-centered approach were found to be effective communicators. Nurses who did not recognize or did not assist with patient physical needs were perceived as not being understanding or empathetic to the patient's situation. The researcher concluded "empathetic communication is an essential prerequisite for the delivery of quality nursing care" (McCabe, 2004, p. 47). Workload, lack of organizational support for a patient-centered communication, and lack of nurse knowledge of what patients' value in the nurse-patient interaction hinder nurse-patient communication. This research supported investing in teaching nurses empathetic and patient-centered communication (McCabe, 2004).

McLafferty, Williams, Lambert, and Dunnington (2006) conducted a cross-sectional study to examine if surgeons used optimal communication behaviors and if patients or family members would recommend surgeons who did not use optimal communication behaviors to family members or friends. A researcher-developed questionnaire with minimal demographics and 10 yes/no questions was distributed to the patients or patient designee (N = 1,514) of 39 surgeons. Unfortunately, no information on instrument reliability or validity was reported. The survey was primitive and the yes/no questions were based on the acronym PAUSE (P = personal connection, A = allow for questions, U = understandable, S = sit down, E = educate). Surveys were distributed by ambulatory care aides at a time that was convenient and on what was described as "a sample of days" from August 2002 to March 2003 and from March to July 2004 (McLafferty et al., 2006, p. 617). In one out of six patient-surgeon encounters (16.3%), patients reported that a minimum of one out of seven optimal communication behaviors were omitted by the surgeon. These encounters were defined as suboptimal patient experiences. Patients identified (a) getting to know the patient as a person, (b) asking if there were any questions, and (c) educating the patient as the top three optimal communication behaviors for a surgeon. However, even though no optimal communication behaviors were omitted during the surgeon-patient encounter, patients reported they would not recommend five surgeons to family members or friends. McLafferty and colleagues (2006) concluded "other factors or communication behaviors" contribute to suboptimal surgeon-patient encounters (p. 621).

Lack of Reciprocity Between the Patient and Provider

Solomon, Surprenant, Czepiel, and Gutman (1985) reviewed a variety of person-to-person encounters common in industries such as healthcare where the purpose of the encounter was to provide a service instead of selling a product. They applied role theory to the service encounter and concluded there should be "high inter-role congruence" with a shared experience between the service provider and recipient of the service (Solomon et al., 1985, p. 109). In healthcare, Travelbee (1971) proposed that the patient relationship is a reciprocal process and dehumanization by the patient or nurse hinders the establishment of a human-to-human relationship. Krupat, Bell, Kravit, Thom, and Azari (2001) examined patient-centered care from the perspective of the physician and patient. Data were obtained from the Physician Patient Communication Project (PPCP), a large observational study that included physicians ($N = 45$) and patients ($N = 909$). Increases in the strength of the physician-patient relationship and in the degree of patient-centered care were not correlated with an increase in patient satisfaction with the visit (Krupat et al., 2001). The study results challenge the effectiveness of the initiatives that focus purely on patient satisfaction or patient-centered care.

Steihaug and Malterud (2002) reported using a qualitative action research design in a study of 31 women with a history of chronic muscular pain to explore "recognising interaction" in clinical practice (p. 151). Twenty-four women completed the entire treatment program, which consisted of 1 hour of movement training every week followed by a 1-hour discussion group facilitated by a physician for 10 months. Schibbye's Part Process Analysis (PPA) method, a qualitative approach used to study interactions at the microlevel, was used to analyze the video recordings of 11 discussion groups. In PPA,

verbal and non-verbal communication is analyzed with a focus on "how the interaction

develops," "reciprocity in the interaction," and participant behavior "during the

interaction process" (Steihaug & Malterud, 2002, p. 152). The authors concluded that

"reciprocal recognition can facilitate change and development" within an interaction

through sharing, understanding, and confirmation of another's experience (p. 154).

Street, Gordon, and Haidet (2007) used an ecological approach to collect data

within a larger cross-sectional study of 10 public and private care clinics. An ecological

approach was selected because it was recognized that more than one variable influences

the process of communication between physician and patient. Six to 10 regularly

scheduled patients (N = 207) of 27 physicians. The median number of patients per

physician was seven, with a range of 3–11. In addition to pre- and post-encounter surveys

completed by physicians and patients, two coders rated physician-patient encounters with

an adapted version of the Patient-Center Communication Scale, an adapted version of the

Perceived Involvement in Care Scale, and the Roter Interaction Analysis System Global

Affect Scale (Street et al., 2007). Convergent validity was demonstrated by using two

coders not associated with the study and intra-class correlations to assess reliability.

Significant correlations were reported for all measures. Findings supported a mutual

influence in physician-patient communication. Reciprocity was perceived as such a

strong feature within the patient-physician encounter that negative or positive

communication by either the patient or physician in some encounters was sufficient to

provoke a comparable response from the other. Street and colleagues (2007) identified as

a limitation of the study their failure to examine the origins of the negative or positive

communication. This study and other studies exploring the variables associated with

difficult encounters exemplify the void in understanding what specifically occurs during a healthcare patient encounter that makes some encounters difficult.

Cumulative Effects of Difficult Encounters on Healthcare Professionals

Frequent and repetitive difficult encounters impact physicians and nurses. Crabbe and colleagues (2002) reported a weak positive correlation in nurses between burnout and verbal abuse, threatened assault, and violence. An and colleagues (2009) report a significantly higher frequency of burnout and dissatisfaction in physicians who experienced more frequent difficult encounters in comparison to physicians who reported medium or low frequency (p <.05). Unrealistic patient expectations and dissatisfaction with care were two reoccurring themes associated with difficult encounters in several studies (An et al., 2009; Elder et al., 2009; Jackson & Kroenke, 1999; MacDonald, 2007b; Weingarten et al., 2010).

Bakker, Schaufeli, Sixma, Bosveld, and Van Derendonck (2000) conducted a 5-year longitudinal study of 207 general practitioners (GPs) to test the hypothesis "that demanding relationships with patients are indirectly related to burnout through the experience of a lack of reciprocity" (p. 428). They concluded that "demanding contacts with patients—for example repeated complaints and threats—may lead to the perception that there exists a lack of reciprocity, which, in turn, causes feelings of emotional exhaustion" (p. 437). They further concluded "It is not patient demands in itself, but perception of imbalance in the relationship between GPs and their patients that initiates the burnout syndrome" (p. 437). Results also suggested "emotional exhaustion, in turn, evokes a callous and cynical attitude towards patients (depersonalization), and a reduced feeling of competence" (Bakker et al., 2000, p. 437). These findings are congruent with

the definition of the difficult patient as "a problem of relationship," (Anstett,1980, p. 286). Repeat experiences with difficult patient encounters has potential long-term workforce consequences. The Bakker et al. study (2000) supports further research to explore the patient-provider relationship and prepare providers for potential non-reciprocity in patient-provider encounters.

Summary

This chapter has reviewed the state of the science on difficult patient encounters. An electronic and archive search of the literature generated minimal references and even less on the topic of difficult encounters between nurses and patients. The majority of the research on difficult encounters has been conducted from the perspective of physicians. A gap thus exists in the nursing literature. Literature exploring violence in healthcare, variables associated with difficult encounters, and the cumulative effects of difficult encounters on healthcare professionals were included in this review because the topics were considered relevant to understanding difficult encounters between nurses and patients. Travelbee's (1971) Human-to-Human Relationship Model guided the literature review.

Conclusion

Difficult encounters between HHC RNs and patients have not been studied. An empirically informed definition of difficult encounters was not located in the literature, and strategies to prevent or de-escalate difficult patient encounters reflected opinion not research. A substantial amount of the empirical literature has focused on the characteristics of patients labeled as difficult. This review of the literature supports Koekkoek and colleagues' (2006) conclusion that a consensus exists in the literature

regarding the characteristics of difficult patients. Yet there is no consensus or empirical evidence that patient characteristics or provider behaviors are the sole catalysts for difficult encounters

Difficult encounters between nurses and patients have been studied in the hospital setting but not in HHC. The concept of difficult encounter is immature, and a research-derived or evidence-based definition of what constitutes a difficult encounter has not been proposed. Nursing, in particular, has documented an increased incidence of patient or companion verbal or physical violence in a variety of practice settings, indicating the importance to nurses of being able to recognize cues that an encounter may be turning difficult in order to try to prevent actual violent encounters. It is imperative that healthcare professionals are alert and able to recognize and respond effectively to difficult encounters (Sellers et al., 2012). Understanding what occurs during nurse-patient encounters that affects the development of human-to-human relationship or rapport is critical to nurse and patient safety, particularly in HHC.

CHAPTER 2

THEORETICAL FRAMEWORK

Introduction

Travelbee's Human-to-Human Relationship Model (1971) provides a framework to study human relationships (Meleis, 2007). This model is applicable to understanding HHC RN and patient interactions with a focus on encounters that were or had the potential to become difficult. Components of the Travelbee Model (1971) guided the literature review and influenced the development of the interview guide for this study. This chapter will review Travelbee's Human-to-Human Relationship Model.

Purpose of the Theory

The purpose of Travelbee's (1971) Model was to conceptualize the behaviors and process that she proposed would lead to rapport between a nurse and a patient. The five-phase Human-to-Human Relationship Model begins with the original encounter between nurse and patient, continues with appreciation for emerging identities, progresses in response to evidence of empathy followed by sympathy, all leading to rapport or a human-to-human relationship. Travelbee (1971) described, explained, and predicted behaviors that fostered or compromised the human-to-human relationship. Travelbee's (1971) theory differs from other nurse theorists in that she attributed labels such as nurse and patient as contributing to stereotypes that hindered the development of human-to-human relationships. The words patient and nurse were used solely to communicate her theory. The patient is a human being or "ill person" (Travelbee, 1971, p. 17). The nurse is a human being with the knowledge and skills to assist the ill human being.

Joyce Travelbee has been cited in the nursing literature since the mid- to late-1960s. She is recognized as one of the first 10 nurse theorists since Florence Nightingale and one of two nurse theorists for the year 1966 (Chinn & Kramer, 2011). She contributed to advancing nursing care, process, and theory (Chinn & Kramer, 2011; Hall, 1997; Marriner-Tomey, 1994; Marriner Tomey & Raile Alligood, 2009; Meleis, 2007; Nordby, 2004; Nystrom, 2007). Travelbee is considered a first-generation nurse theorist (Hall, 1997). First-generation nurse theorists were challenged to define nursing, communicate nursing outcomes, and to substantiate how nursing differed from other disciplines (Chinn & Kramer, 2011; Hall, 1997; Nystrom, 2007). The first generation of nurse theorists were credited with providing the foundation for the nursing process (Chinn & Kramer, 2011; Hall, 1997). Travelbee was described as "a prolific reader whose office was crammed with files of bibliography cards" (Marriner-Tomey, 1994, p. 335). She was influenced by existentialists Vicktor Frankl and Rollo May and by nurse theorist Ida Orlando (Marriner-Tomey, 1994; Meleis, 2007). The literature also reported that her work was influenced by Hildegarde Peplau (Hall, 1997; Nordby, 2004).

Travelbee's (1971) Human-to-Human Relationship Model appears to be fused from her understanding of applicable theories, conclusions drawn from the literature, and her own personal nursing experience in Catholic Hospitals (Marriner-Tomey, 1994; Meleis, 2007; Travelbee, 1971). She was perceived as using a "field approach" (Meleis, 2007, p. 370). Joyce Travelbee died during the summer of 1973, and The Human-to-Human Relationship Model was never empirically tested (Marriner-Tomey, 1994). The model may not meet standards proposed for theory evaluation today, but Travelbee's

understanding of the domain of the nursing and the nurse is relevant to exploring nurse-patient encounters.

Major Concepts

Travelbee (1971) proposed that the human-to-human relationship was dependent upon the meaning of illness, human beings, therapeutic use of self, hope, suffering, spirituality, identity, empathy, sympathy, and rapport, reflecting the influence of her previous work at Catholic charity institutions. The human-to-human relationship was thought to be enhanced or hindered by communication, advocacy, and original encounters. There are five phases in the Human-to-Human Relationship Model: original encounter, emerging identities, empathy, sympathy, and rapport. Inferences and value judgments surface during the original encounter. Bonds and appreciation for the uniqueness of the human being develop during the emerging-identities phase. Travelbee (1964, p. 68) describes empathy as "an intellectual and, to a lesser extent, emotional comprehension of another person, important and desirable because it helps us to predict that person's behavior and to perceive accurately his thinking and feeling" is viewed as "the forerunner of sympathy." Sympathy, in contrast, was described as "a desire, almost an urge, to help or aid an individual in order to relieve his distress (Travelbee, 1964, pp. 68–69). Rapport, "a particular way in which we perceive and relate to our fellow human beings," (Travelbee, 1963, p. 70) is the goal of the original encounter, a human-to-human relationship, and the final phase.

In this model, communication is a "reciprocal process" (Travelbee, 1971, p. 94). Communication breakdown occurs when the nurse fails to see the ill person as a human being, does not recognize levels of meaning in communication, does not listen, lacks

reflection when using value statements, uses clichés and automatic responses, has accusatory, blameful, and teasing behavior, and misinterprets by not clarifying an ill person's statements. Travelbee defined the process of dehumanization or human reduction as "the diminishing capacity to perceive ill persons as human beings accompanied by an increase in proclivity to perceive ill persons as an illness, or as a task to be performed, instead of as human beings" (Travelbee, 1971, p. 34). She identified anger as the emotion most commonly expressed by a patient or nurse in response to dehumanizing behavior.

Major Assumptions

The major assumption in Travelbee's theory, "The purpose of nursing is achieved through the establishment of a human-to-human relationship" (Travelbee, 1971, p. 13), is relevant to a study exploring difficult encounters experienced by HHC RN. The HHC RN is a member of a team providing healthcare to a patient, but the HHC RN interacts with the patient one-on-one in their home and frequently may be the only link between the patient and the healthcare team. Travelbee asserts that a good relationship between the patient and the nurse is likely to optimize the outcomes of the interaction.

Effective communication is identified as vital to the human-to-human relationship and a major assumption of Travelbee's theory (1971). Specifically, she stated, "A major premise of this work is that the nurses need to know if communication is taking place in nursing situations; if the exchange messages have been understood by all concerned" (Travelbee, 1971, p. 102). Travelbee (1971) clearly articulated her perspective of the role of the nurse in her assumption that "a nurse is able to establish rapport because she possesses the necessary knowledge and skills required to assist the ill

persons, and because she is able to perceive, respond to, and appreciate the uniqueness of the ill human being" (p. 153). In this study, I will seek to describe how HHC RNs identify and respond to difficult encounters and what, if any, strategies they used to establish rapport, or a human-to-human relationship.

Illustration of the Human-to-Human Relationship Model

Travelbee (1971) did not include an illustration or diagram of the Human-to-Human Relationship Model in *Interpersonal Aspects of Nursing.* Hobbie and Lansinger (n.d.), as illustrated in Marriner-Tomey, 1994), conceptualized Travelbee's Model as a pyramid starting at the base with the original encounter with patient connected in a half circle connected by a line to nurse in a half circle. The circle gradually closed to mark progression through the next three phases, concluding with rapport at the apex with patient and nurse enclosed within the circle (Hobbie and Lasinger, n.d., as illustrated in Marriner-Tomey, 1994). However, the pyramid schematic design does not reflect forward progression through the five phases described by Travelbee (1971) in her publication. Instead, Hobbie and Lansinger's illustration (n.d., as cited in Marriner-Tomey, 1994) implies a hierarchal order and does not account for difficult encounters.

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Summary

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This chapter has reviewed Travelbee's (1971) Human-to-Human Relationship Model. Early nurse theorists such as Travelbee were intuitive and visionary in their understanding of the domain of nursing and the nurse-patient encounter. The Human-to-Human Relationship Model was innovative and is relevant to the understanding of patient encounters. Travelbee's Human-to-Human Relationship Model conceptualizes a five-phase process that starts with the original encounter with the intent to establish rapport or

a human-to- human relationship. Travelbee's (1971) Human-to-Human Relationship

Model is applicable to research exploring nurse-patient encounters that are perceived by

the nurse as difficult.

CHAPTER 3

RESEARCH METHODS

Introduction

This chapter will provide a description of the research methods to be used to conduct this study. Specifically, the chapter will provide the rationale for use of a QD design: plans for participant recruitment, inclusion and exclusion criteria; data collection methods; proposed data management and data analysis; strategies to ensure trustworthiness and reflexivity; measures that will be taken to protect study participants; and lastly, identification of limitations of the proposed study.

Research Design

The healthcare literature is limited in exploring the context and characteristics of difficult nurse-patient encounters. A Qualitative Descriptive (QD) study will be conducted using one-on-one open-ended interviews to explore HHC RNs' understanding of difficult encounters in the HHC setting. QD is the preferred qualitative approach if the aim of a study is pure description of a phenomenon (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sandelowski, 2000). In contrast to other qualitative approaches, QD researchers analyze data using the participants' descriptions and exact language to describe the problem or issue (Sullivan-Bolyai, Bova, & Harper, 2005). One-on-one or face-to-face open-ended interview was selected as the mode of data collection as its synchronized communication permits flexibility in data collection (Opdenakker, 2006), allows the interviewer to clarify or probe participant responses (Guest, Namey, & Mitchell, 2013) and to directly observe non-verbal communication (Creswell, 2007).

Sample

A purposive sample of a minimum of 20 HHC RNs for one-on-one in-depth interviews and a maximum of 12 HHC RNs for interpretive focus groups will be recruited by the nurse researcher from a visiting nurse association providing services to patients living in Rhode Island and Southeastern Massachusetts. The leadership of HHC will be contacted to gain access to potential study participants. Contact visits will be made by the nurse researcher to counter potential threats to the trustworthiness of the study. Seidman (1991) recommended contact visits to "lay the groundwork for the mutual respect necessary to the interview process" (p. 38) and to demonstrate to the potential participants that the researcher is invested in the project. Group contact visits will strengthen the credibility of the nurse researcher by providing consistent explanation of the study by one person (Seidman, 1991) and the opportunity for the nurse researcher to directly address questions or concerns that may hinder the recruitment process. The nurse researcher will also emphasize during the contact visits her independence from the organization (Shenton, 2004) and that the organization will not have access to names of study participants or study data. One or more on-site contact visits will be made to explain the study to potential participants.

Becker (1998) recommended caution with accessing leadership of organizations because "institutions always put their best foot forward in public" (p. 91). However, the recruitment of potential study participants from an organization will maximize the potential that a diverse sample of HHC RNs will be recruited. Yet a risk does exist that the recruitment process could be influenced by leaders of the organization. They could encourage the participation of some while directly or indirectly restricting the

participation of others (Becker, 1998; Shenton & Hayter, 2004). There also exists the potential for underreporting of incidents and concerns of employer retribution for information shared (Shenton, 2004).

Purposeful sampling was selected to ensure study participants have an understanding of the research problem and the primary phenomenon (Creswell, 2007). Samples in QD studies tend to be larger than other qualitative approaches (N = 20–50) (Sullivan-Bolyai et al., 2005). A larger sample will increase the probability that phenomenal variation will be maximized (Sandelowski, 2000). Recruitment and interviews will be conducted until there is informational redundancy or saturation (Sandelowski, 1995). This study will be limited to RNs who have experience in HHC including RNs currently working and those who previously worked in HHC. RNs not currently working in HHC will be included in the study because there is the possibility a difficult encounter may have influenced the RN's decision to work in another setting. Inclusion criteria include (a) licensed RNs, (b) age 18 years or older, (c) previous or current employment as an RN in HHC, and (d) ability to understand, read, and write English.

Setting

All interviews will be conducted in person with HHC RNs living in Southeastern Massachusetts or Rhode Island. This area is within a reasonable driving distance for ease of data collection. It is anticipated there will be variation in socioeconomic status, culture, ethnicity, and geographic healthcare spending. The initial one-on-one interviews will be conducted in a private, distraction-free location (Creswell, 2007) at a mutually convenient date and time. Initial interviews will be conducted in person but follow-up

interviews to clarify, amplify, or confirm information from the in-depth interview or to ask about a topic not covered in that interview that emerged as important in the course of the study may be completed in person, by phone, or by e-mail.

Data Collection

An invitation to participate in the study will be distributed to nursing staff during the contact visits and e-mailed to the organization's chief executive officer (CEO) with the request to forward the study invitation (Appendix A) to the work e-mail of nursing staff. As potential study participants are recruited and accrued, an effort will be made to maximize range and variance in age, gender, and demographic characteristics. An effort will be made to recruit one negative case (HHC RN who has not experienced a difficult encounter) and an RN who no longer works for the organization. HHC RNs who contact the nurse researcher but do not meet the criteria needed to maximize range and variance in the one-on-one interviews may be invited to participate in one of the interpretive focus groups. A minimum of six and a maximum of twelve HHC RNs will be recruited to participate in two interpretive focus groups each with three–six HHC RNs. Interpretive focus groups will occur after completion of the one-on-one interviews, and members of the groups will not have participated in the one-on-one interviews.

It is anticipated that it may be challenging to recruit males and non-white HHC RNs as they represent a small percentage of HHC RNs, but every effort will be made to include that sample. There is also the potential that one organization may not yield a sufficient sample to explore the phenomenon. The specific visiting nurse association was selected because of the size of the organization and the expanded geographic territory serviced. If a purposive sample of a minimum of 20 HHC RNs for the one-on-one

interviews and minimum six HHC RNs for the focus groups cannot be recruited from one organization, a secondary organization will be contacted to participate in the study. There will be no compensation for study participation to the organization or individual participants.

HHC RNs who respond to the recruitment letter or e-mail will be contacted by telephone or e-mail to confirm the potential participant meets the study criteria and to select a mutually convenient date, time, and private setting to meet with the nurse researcher for the informed consent process and, if the individual consents, the in-depth interview. When obtaining verbal consent for the one-on-one interview the nurse researcher will give each potential study participant a study fact sheet that describes the study purpose, that participation is voluntary, that no protected health information (PHI) questions will be included in the interview, the rights regarding no longer participating in the study, procedures to keep responses confidential, and potential risks (Appendix B). After the potential interviewee has had a chance to read the study fact sheet, the nurse researcher will encourage questions and ask the potential participant questions to validate understanding of study participation (Martindale, Chambers, & Thompson, 2009). Each participant will then be invited to give verbal consent before the start of the one-on-one interview.

A semistructured interview guide (Appendix C) will be used by the nurse researcher to conduct an open-ended, one-on-one in-depth interview. Each initial interview will begin with the same question. Participants will be asked to reflect upon their nursing experience and describe a difficult encounter with a patient. Additional questions will be asked to discern the characteristics of the encounter. If not shared by the

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participant, specific questions will be asked to probe how the patient encounter and interaction evolved, cues the HHC RN recognized during or in retrospect that the encounter would turn difficult, and what strategies the HHC RN used to resolve or minimize the difficulty in the encounter. The term *difficult* was removed from the study fact sheets and interview guide to minimize leading or influencing participant responses and to propose a definition that emerges from the data. The interviews will last approximately 60–90 minutes. With the permission of the interviewee, the interview will be digitally recorded. Field notes will be taken during the interview.

After the open-ended interview is completed, each study participant will be asked to complete a demographic data form (Appendix D) as suggested by Weiss (1994). This information will provide a detailed description of the study sample such as years as an RN, years as a HHC RN, present practice setting, education, gender, and ethnicity. Interviews will continue until the researcher determines there is informational redundancy and analysis of data will, at a minimum, inform an empirically derived definition of difficult encounters. One or more short follow-up interviews in person, by phone, or by e-mail may be conducted for clarification, amplification, or confirmation of information from the in-depth interview or to ask about a topic not covered in that interview that emerged as important in the course of the study. These follow-up interviews will also be digitally recorded or if conducted via e-mail, a copy of the e-mail will be added to the data files.

The risk to study participants' privacy is minimal. The interviews will be conducted in a private setting. The nurse researcher will maintain study participant confidentiality by assigning each participant a pseudonym from a published list of names

in descending order (Appendix E). Participants will not be informed of their assigned pseudonym. Immediately following each interview, all audiotapes and field notes will be labeled with the assigned pseudonym. The pseudonym will be used in written notes taken during interviews, on the demographic data form, and transcripts of authorized digitally recorded interviews. Some participants may experience distress as they discuss a difficult encounter. As recommended by Kammerer (2012), counseling information will be provided to all participants at the end of interview.

Prolonged engagement is one technique used by qualitative researchers to build trust with study participants and to strengthen the credibility of findings (Lincoln & Guba, 1985). In this study, one nurse researcher with professional experience in HHC and nursing leadership will be the contact for the study and conduct every interview. Potential participants will learn of the study through the study invitation forwarded by the organizational leader or during an on-site visit by the nurse researcher to the organization. The organizational leader may have knowledge of whom they forwarded the study invitation to but will not know which potential participants contacted the nurse researcher. The willingness of others to introduce the study on behalf of the nurse researcher lends credibility to the study and reputation of the nurse researcher (Shenton & Hayter, 2004). Once contacted by potential participants, the nurse researcher will have the opportunity to build trust and develop rapport (Shenton & Hayter, 2004). The nurse researcher will have contact with potential study participants by telephone or e-mail to schedule the initial interview, during the 60–90 minute interview, and during one or more short follow-up interviews in person, by phone, or by e-mail. There is no threat of

coercion because the nurse researcher does not directly know or work with any of the potential study participants.

Data Management

All study materials will be securely stored by the nurse researcher, with hard copies kept in a locked cabinet and password-protected electronic copies. The study ID log will be stored separately from other study materials. Electronic study files will be stored in a UMASS password-protected encrypted drive assigned to the nurse researcher. Transcriptions of digitally recorded interviews will be done by a professional transcriptionist and confirmed by the nurse researcher. Access to data will be limited to the researcher and the dissertation committee members. All data, including digital recordings of interviews, will be securely stored in a locked cabinet until data analysis is completed, at which time they will be securely destroyed. Opportunities for transferability will evolve from the sharing of study findings in oral and written presentations (Wiles, Crow, Heath, & Charles, 2006).

Data Analysis

Data collection and analysis will be an iterative process (Polkinghorne, 2005). The nurse researcher will repeatedly review transcribed interviews, listen to interview recordings, re-read interview notes, reflect upon findings, and memo. Memos will include but not be limited to initial thoughts post participant interviews, preliminary analysis of data, challenges encountered, and outcomes of peer debriefing. The analytic method of qualitative content analysis (QCA) will be used to analyze text data.

The preferred method for data analysis in QD is QCA. QCA is data derived (Sandelowski, 2000). Description of the context and characteristics of difficult patient

encounters is limited. An inductive approach (Elo & Kyngas, 2008) using conventional QCA (Hsieh & Shannon, 2005) is recommended for the analysis of multifaceted and poorly understood phenomena. Conventional QCA entails analyzing text data collected from interviews using open-ended questions and probes. Codes are derived from the initial thoughts of the researcher and with each reading of interview transcripts. Related codes are grouped together into categories. Relationships, antecedents, outcomes, and definitions emerge from codes, subcategories, and categories (Hsieh & Shannon, 2005).

In this study, each interview will be coded statement by statement. The data will be systematically categorized within codes that emerge from the data (Morgan, 1993; Sandelowski, 2000). Codes will be counted to detect patterns in the data and to interpret what contributed to the patterns (Morgan, 1993). The constant comparison method (CCM) will be used to compare codes within interviews and develop patterns or themes between interviews (Boeije, 2002). Descriptive statistics will be used to analyze sociodemographic data from the self-report questionnaire.

Dodson (1999) recommended incorporating informants "into different stages of research, including the interpretive stages" (p. 247). Interpretive focus groups offer another technique to triangulate or validate data from one-on-one interviews. In an interpretive focus group, the researcher methodically shares verbally or in writing previously collected data and researcher-derived themes to the group for their analysis (Dodson, 1999). Morgan (1997) recommended two structured focus groups of four–six participants as optimal if the intent is to interpret data from one-on-one interviews. The size of the focus group should be determined by the topic and the anticipated level of participant involvement. Small focus groups generate more detailed information and a

focus group of three with a defined purpose was perceived as productive as a focus group of six. Morgan also (1997) recommended researchers consider potential ethical issues such as privacy that may arise with focus groups. Focus group members are aware of each participant's responses (Morgan, 1997) and, in this study, the potential exists that focus group participants may know each other.

Two interpretive focus groups each with three–six HHC RNs will be employed to validate analysis of the data and to isolate additional themes not identified during the one-on-one interviews. Interpretive focus group members will not have participated in the one-on-one interviews. Each participant will be given a study fact sheet (Appendix F) in private when obtaining verbal consent before the start of the interpretive focus group. Each participant will also be asked to complete the demographic data form before the start of the focus group. The nurse researcher will use a structured approach. The small focus groups will provide more privacy and the opportunity for each group member to contribute detailed information. A minimum of two focus groups will strengthen the credibility of the data whether the data are similar or different (Morgan, 1997). My own personal knowledge will also be incorporated into the analysis process. Analysis will be informed by my knowledge gained from over 17 years of experience as a HHC RN and self-reflection (Shenton, 2004).

Trustworthiness

In a qualitative approach, the researcher uses techniques to demonstrate credibility, transferability, dependability, and confirmability (Guba, 1981; Lincoln & Guba, 1985). Credibility will be demonstrated by contacting and recruiting potential study participants through an HHC organization. The nurse researcher will also look "to

identify the case that [would] likely upset [her] thinking" (Becker, 1998, p. 87). Credibility, dependability, and confirmability of data will be demonstrated by the nurse researcher participating in ongoing peer debriefing with one or more of her committee members and maintaining an audit trail (Lincoln & Guba, 1985). An audit trail will permit review of data by peers or superiors at any time during the study, the opportunity for triangulation of data, and the potential for study replication in the future (Guba, 1981; Lincoln & Guba, 1985; Shenton, 2004). At a minimum, the nurse researcher will maintain a code book, data document matrix, and reflexivity journal (Lincoln & Guba, 1985). In this study, the nurse researcher will use reflexive bracketing. She will record thoughts and concerns surrounding her experiences as HHC RN, nursing leader, and understanding of Travelbee's Human-to-Human Relationship Model that may have influenced one-on-one interviews or data analysis. It is important for qualitative researchers to specify the type of bracketing used or risk questions of the trustworthiness of the data (Gearing, 2004).

Limitations

Recruitment of a purposive sample through an organization poses threats to trustworthiness of the study. The organizational leader may be selective to whom the leader forwards the study invitation. Recruitment from one organization may not yield an ethnic- and gender-diverse sample. Generalizability will be limited given the geographic restriction on data collection and the common culture shared by many who reside in Southeastern Massachusetts and Rhode Island.

Ethical Considerations and Protection of Human Subjects

Respect for persons, beneficence, and justice are recognized as basic principles in research with humans (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Medicine [NCPHSBBM], 1979). Measures will be taken to ensure the protection of human subjects (NCPHSBBM, 1979), respect for participant privacy (Weiss, 1994), and demonstration of trustworthiness in data collection (Guba, 1981; Lincoln & Guba, 1985; Whittemore, & Melkus, 2008). In this study, all participants will be professionals over age 18, and the interviews will explore only their professional work. The purpose of the study, volunteer nature of participation, rights regarding no longer participating in the study, and procedures to keep responses confidential will be communicated in the recruitment invitation and study fact sheets. During the informed consent process, potential participants will have an opportunity to ask and have answered any questions they may have about the study. When the nurse researcher is confident that they understand the nature of the study and their participation in it, she will ask if they are willing to start the interview or participate in the focus group.

The nurse researcher will not ask about PHI in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Participants will be instructed to not disclose PHI during their interview. All interviewees are RNs who are practiced in protecting PHI and are well informed of the potential consequences to breaches in PHI. It is highly unlikely an interviewee will reveal PHI. Should such a breach occur in the course of an interview, the nurse researcher will stop the interview and remind the interviewee that no PHI should be included in responses. The PHI will be deleted from digital recording of the interview. Participating in the interviews carries minimal risk.

interviews carries minimal risk. Participants may experience some emotional distress at being asked about or describing their difficult experiences in HHC and will be given contact information for counseling services (Appendix G) at the end of the interview.

Summary

A QD study using QCA as the analytic method to analyze data from one-on-one interviews with HHC RNs will be used to explore the context and characteristics of difficult encounters between HHC RNs and patients. The proposed study will add to our understanding of the phenomenon of difficult patient encounters by including the perspective of HHC RNs. Data derived from rich and credible descriptions of difficult encounters by HHC RNs will contribute to the empirical literature and support the creation of an empirically informed definition of what constitutes a difficult encounter in the home healthcare setting. Identification of cues that encounters may become difficult may provide a basis for future intervention work focusing on prevention of difficult encounters in HHC.

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EXECUTIVE SUMMARY

Exploratory Study of Nurse-Patient Encounters
in Home Healthcare

| Original Proposal	Modification to study	Rationale
A purposive sample will be recruited by the nurse researcher from a visiting nurse association providing services to patients living in Rhode Island and Southeastern MA.	State nursing associations, visiting nurse associations (VNAs), HHC agencies, or state nurse associations representing nurses who provide services to patients living in CT, MA, and RI were contacted to participate in the study.	Geographic area for data collection expanded from RI and Southeastern MA to include CT and all of MA because of difficulty gaining access to a visiting nurse association providing services to patients living in RI and Southeastern MA.
Format of demographic data form.	Early study participants asked for clarification about which box to check off when completing form. Demographic data form modified to reposition check-off box for level of education.	Increase clarity of form.
The leadership of HHC organization providing services to patients living in RI and Southeastern MA will be contacted to gain access to potential study participants. An invitation to participate in the study will be distributed to nursing staff during the contact visits and e-mailed to the organization's CEO with the request to forward the study invitation to the work e-mail of nursing staff.	HHC and professional nursing organizations in CT, MA, and RI were contacted to share study invitation with HHC RNs and members. A secondary recruitment strategy was employed. HHCs shared the study invitation with other HHC RNs unknown or not well known to the nurse researcher.	Additional recruitment strategies employed in response to slow recruitment from organizations.
Non-applicable.	Initial 10 HHC RNs to assist with recruitment was increased to 20.	Needed to increase potential pool of participants
Data to be collected from a purposive sample of a	Data collection was completed with one-on-one interviews.	Discussion with committee resulted in stopping with

minimum of 20 HHC RNs for one-on-one in-depth interviews from one or two HHC organizations. Two interpretive focus groups each with three–six HHC RNs will be employed to validate analysis of the data and to isolate additional themes not identified during the one-on-one interviews.	No focus groups were conducted.	one-on-one interviews, given richness and credibility of data collected during the interviews.

Exploratory Study of Nurse-Patient Encounters in Home Healthcare (HHC)

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The literature on difficult patient encounters evolved from early writings on *difficult patients*

Difficult Patients

Difficult Encounters
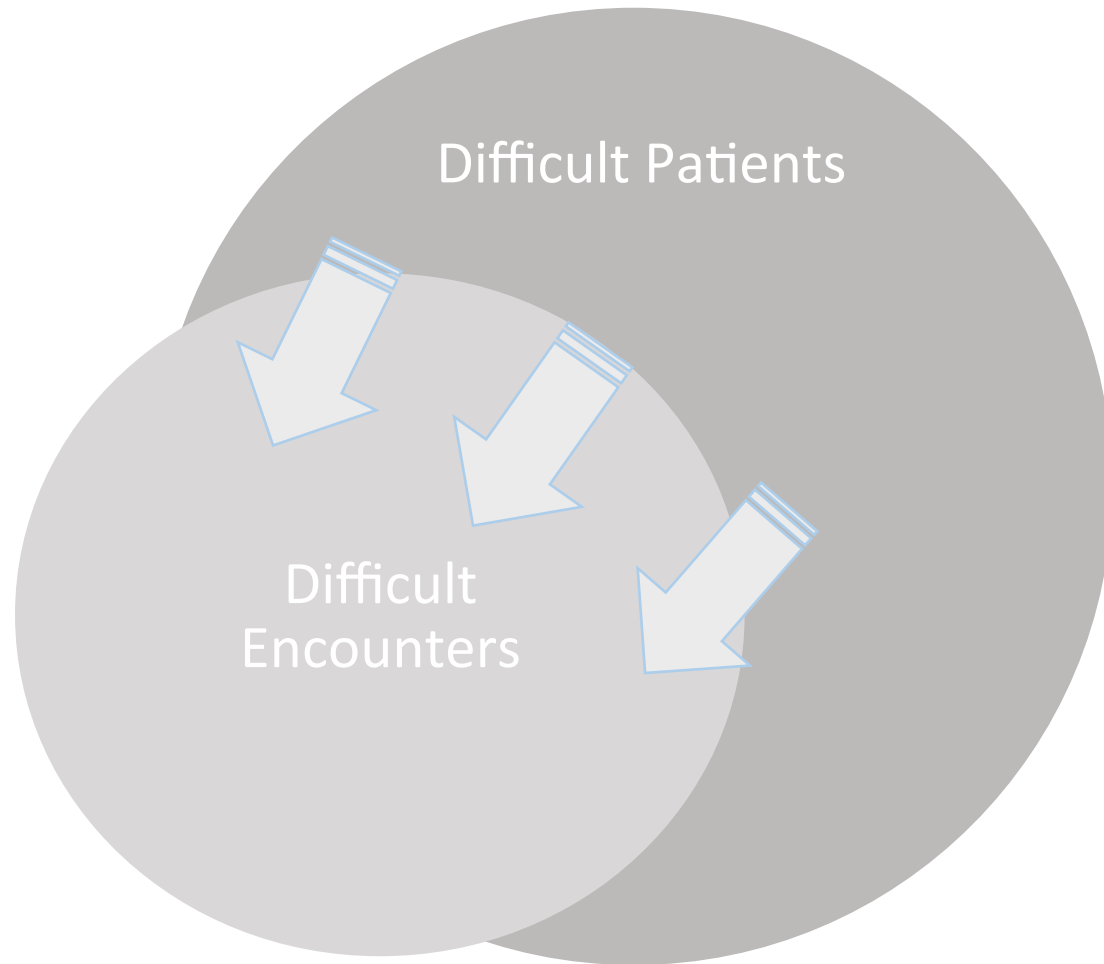
Difficult Patients

- *Difficult patients* are described as someone whose emotional, physical, or emotional and physical needs are not met (Peterson, 1967)

- *Difficult patients* have been labeled as dependent clingers, entitled demanders, manipulative help-rejecters, self-destructive deniers (Groves, 1978), heartsink (Finlay, 2005; O'Dowd, 1988), blackholes (Gerrard & Riddell, 1988), and bothersome (Evans, 2009)

- Patients with a psychiatric diagnosis, alcohol abuse, and substance abuse are frequently labeled as difficult (Hahn et al., 1994; Hahn et al., 1996; Laskowski, 2001; Sellers et al., 2012)

Difficult Patient Encounters

▪No research-derived, evidence-based, or even expert-consensus definition of a difficult encounter was found in the literature

▪Most of the research on difficult patient encounters is limited to interactions between physicians and patients in clinic or office settings (An et al., 2009; An et al., 2013; Hahn et al., 1994; Hahn et al., 1996; Hinchey, & Jackson, 2010; Jackson & Kroenke, 1999; Sellers et al., 2012; Steinmetz & Tabenkin, 2001)

▪*Only one nursing study* explored the origins and context of difficult patient encounters (MacDonald, 2007)

There is an increasing incidence of physical assaults against nurses

82.1% of RNs in an ED were physically assaulted (May & Grubbs, 2002)

- Nurses have been identified as "among the most assaulted workers in the American workforce" (NACNEP, 2007, p. 2)

- Patients are reported as the leading perpetrators of violence against nurses (Jackson, Clare, & Mannix, 2002)

- Verbal or physical abuse was reported as the first sign of a problem in nurse patient encounter in several studies (Canton et. al., 2009; Chambers, 1998; Crabbe, Alexander, Klein, Walker, & Sinclair, 2002; May & Grubbs 2002; McPhaul, Lipscomb, & Johnson, 2010; Pejic, 2005)

Understanding the context of a nurse-patient encounter that is not going well is critical to ensuring nurse safety

- Violence against nurses was recognized as one of the three top priorities confronting the nursing profession (NACNEP, 2007)

- A weak but positive correlation has been reported in nurses between burn-out and verbal abuse, threatened assault, and violence (Crabbe et al., 2002)

- In the HHC literature significant correlations between exposure to workplace violence and job satisfaction, turnover intention, and exit intentions have been reported (Canton et al., 2009)

- The Health Resources and Services Administration projected a 109% increase in the demand for full-time equivalents of HHC RNs between 2000 and 2020 (Biviano, Tise, Fritz, & Spencer, 2004)

The purpose of this study was to explore nurse-patient encounters from the perspective of the Home Healthcare Registered Nurse

Specific Aims

1. Identify cues or common characteristics HHC RNs associate with an encounter turning difficult

2. Describe how the HHC RN responds to difficult encounters and the strategies used to establish a human-to-human relationship or rapport

3. Propose an empirically informed definition of what constitutes a difficult encounter

Study Design – Qualitative Descriptive (QD)

- A QD approach is recommended if the aim of a study is to describe a phenomenon and to answer a practice-derived research question (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sandelowski, 2000)

- QD researchers analyze data using the participants' descriptions and exact language to describe the problem or issue (Sullivan-Bolyai, Bova, & Harper, 2005)

- QD researchers *stay close to the data* during analysis with less emphasis on "reflective or interpretive interplay with existing theories" that is necessary in a study with a pure aim of concept or theory development (Neergaard, Olesen, Andersen, & Sondergaard, 2009, p. 2)

Human Subject Considerations

- Approval was obtained from UMMS IRB

- Respondents to the recruitment e-mail were contacted and for those interested in learning more about the study a mutually convenient date, time, and *private setting* to meet were discussed (e.g., participant's home, car, or library conference room)

- Informed consent obtained just prior to interview

- Contact information for counseling services was provided to *all* study participants (Kammerer, 2012*)*

- Potential study participants were assigned a pseudonym from a published list of first names

Recruitment

Purposive Sample

- An invitation with a brief description of the study was e-mailed or shared in person to select visiting nurse and state nursing associations in CT, MA, and RI with the request that the study invitation be forwarded to the organizational e-mail of HHC RNs

- A secondary recruitment strategy was used and the study invitation was e-mailed to 12 HHC RNs with the request that they share the study invitation in person or by e-mail with no more than five HHC RNs

- Recruitment continued until there was informational redundancy with range and variance in the sample

The purposive sample included 20 RNs

Inclusion Criteria
- ✓ Licensed RN
- ✓ 18 years of age or older
- ✓ Current or previous employment as an RN in HHC
- ✓ Ability to understand, read, and write English
- ✓ Reside in CT, MA, or RI

Recruitment and Data Collection
- 22 HHC RNs responded to the study invitation, with 20 agreeing to participate in the interview
- An effort was made to maximize range and variance in age, gender, and demographic characteristics
- Interviews were completed between November 2014 and June 2015

Participant Demographics (N = 20)

Characteristics	Number	Percentage	Mean	Range
Age			52	23–66
Years Worked as HHC RN			14	0.4–33
Years Licensed RN			24	0.6–45
Gender				
Female	17	85		
Male	3	15		
HHC Primary Position	13	65		
Employment Status				
Not Working HHC	5	25		
Per Diem	2	10		
Part Time	2	10		
Full Time	11	55		
Education Level				
Diploma in Nursing	1	5		
Diploma with Masters in non-nursing field	2	10		
Associate Degree Nursing	3	15		
Bachelor Science of Nursing (BSN)	9	45		
BSN with Bachelors in other field	2	10		
Masters of Science in Nursing	3	15		

Majority
- Self-described as female (85%) and Caucasian (50%) or white (35%)
- Lived in Massachusetts (55%) with others living in CT (35%) and RI (10%)
- Recruited from organizations (70%)
- Currently work in HHC (75%)

Data Collection

Interview
- In-depth open-ended, one-on-one interviews were conducted using a semistructured interview guide

- Each study participant was asked the same first question

    "Reflect upon your experiences as a home health care nurse and tell me about a home visit with a patient that did not go well?"

Demographic Data Form
- Completed *after* interview (Weiss, 1994)

- 16 Questions
  - ✓ Basic demographics
  - ✓ Present and past positions
  - ✓ *Two questions to capture occurrence and frequency of encounters that do not go well*

Data collection and analysis was an iterative process
(Polkinghorne, 2005)

- A combination of Conventional Qualitative Content Analysis (Hsieh & Shannon, 2005), "codifying and categorizing" (Saldana, 2009, p.8), and Constant Comparison Method (Boeije, 2002; Creswell, 2007) were used to analyze data

- Early codes were derived from field notes and developed with more in-depth analysis of the transcribed interviews

- Analysis involved moving between the transcripts of individual interviews, the Active Code Log, and the Memo Log to "codeweave" the data into paragraph form (Saldana, 2009, p.187)

Establishment of Trustworthiness

Credibility	(1) Contact made through organization or HHC RNs (2) Interviews were conducted by a clinically experienced RN with acute care, HHC, and leadership experience (3) Nurse researcher looked "to identify the case that [would] likely upset [my] thinking" (Becker, 1998, p.87)
Dependability	(1) Audit Trail (2) Field notes (3) Reflexivity (memo) (4) Peer Review (advisor access to UMASS drive/debrief)
Confirmability	(1) Data were collected from study participants recruited from more than one organization and HHC RN (Shenton, 2004) (2) Reoccurring topics that emerged during interviews were explored in subsequent interviews to validate and amplify data (Shenton, 2004) (3) Methodical organization of study data allows for potential for study replication in the future (Guba, 1981; Lincoln & Guba, 1985; Shenton, 2004)
Transferability	(1) Applicable to other settings and industries (Lincoln & Guba, 1985)

Four Themes and One Interconnecting Theme Emerged From the Data

Objective Language

Navigating the Unknown

Acknowledging Not All Nurse-Patient Encounters Will Go Well

Looking for Reciprocality in the Encounter

Mitigating Risk

Theme 1
HHC RNs voiced a preference and need for non-judgmental and factual language to describe patient encounters

Objective Language

"You want to be as objective as possible (pause) obviously this [medical record] *is a legal document and you don't want to be terming anybody.*"

"You try not to ever use the word difficult patient."

"What's difficult for you is not difficult for me."

"I think the word difficult is shunned, and I think that we're programmed to use the word challenged because if you say difficult... people perceive that as you [are] judging the patient."

Theme 2
What was *unknown* to the HHC RN emerged as a dominant factor in encounters that posed a direct threat to the RN

"What's not written there [medical record] *can hurt me."*

"You listen to their voice [during phone call], *the way they talk…how they're receiving you, I think you're just intuitive and your radar is up."*

Navigating the Unknown

"Trust my instincts…it's been said to me by… policemen [and others]*…if the hairs on the back of your neck go up, pay attention because I think in that situation I first described, there were subtle hints and I didn't pay attention."*

"Sometimes you would call police departments and ask them…is it safe after dark or whatever…it could be in a great area, you don't know what you're going to walk into…You just hope…what you're walking into is safe"

HHC RN Strategies to Navigate the Unknown

Review the patient record for history of
- acting out in hospital or signed out against medical advice
- substance or alcohol abuse
- psychiatric diagnosis like post-traumatic stress disorder
- health condition caused or aggravated by trauma such as a gunshot
- incarceration
- evidence or suspicion of domestic abuse

Initial phone encounter
- ask who else lives or will be in the home when the RN is present

✓ **Use of cellphones with global positioning systems (GPS)**

Theme 3
HHC RNs felt a connection was made if there was a sign of reciprocality

"You're not afraid to shake someone's hand that might be dirty or smell...you know, that kind of thing, and I think people realize and pick up on that you are willing to, you know, be there for them."

"You want to feel a little more human to them...you know you want them to feel like you're a person because they're a person. They're vulnerable and you know everything about them...I usually talk about most things with them."

Looking for Reciprocality in the Encounter

"The door opened immediately and the patient was sitting on a three-legged stool...and behind her the room was knee deep in crap. Everything that you could imagine...with just a small path to wander through it...I think she pulled up a chair or something and I basically sat in the doorway."

"Often where they're irritated and or exhausted...they snap at you a little bit... then they'll say you know I'm sorry. I'm just so tired I don't mean to take it out on you."

HHC RNs Strategies to Promote Reciprocality and Positive Reciprocity

- Recognize patient or caregiver priorities

- *"Build trust"* by resolving immediate concerns

- Identify opportunities to demonstrate HHC RN is professional, has *"clear value,"* and is competent

- Consistency in approach and HHC RN if possible

- Position self so as not to *"stand over them"*

- Assess for cues to proceed and *"ask before do"*

- Subsequent visits *"go in with a forgiving mind"*

The majority of in-home encounters that do not go well were resolved with silence, listening, apologizing, or completing a task

Theme 4

Each HHC RN described at least one incident in which they had cause to be *"scared"* or reported hearing the stories of others

Mitigating Risk

"If there are flags…a patient that was very combative in the hospital, you know yelling at the nurses, I'll bring that forward right away so that we know going in there could be an issue."

"She was very, very, very angry…I didn't feel like I was in harm's way in any way but I certainly kept my distance. Certainly stayed near her husband"

"I used to share a lot more with them [patients] and then when you find out someone's a level-3 sex offender and you're thinking crap I didn't want to talk about my daughter."

"She called us to come. Once we came in, she slammed the door, she said if you stay here, I'm [going to] kill you!...

I had to call 9-1-1."

Subtheme 4A

Anger and frustration are pervasive

- *"What are they yelling and screaming at or about?"*

- *"People become angry for whatever reason… now I'm the next person they're seeing…I let them vent."*

Triggers and Targets

Heightened Awareness

Crossed the Line

Red Flag

- *"She was in bed and not coming after me…And he was, he was a big man coming towards me."*

- *"They were very strongly opinionated about it and even to the point where they were like glaring at me."*

HHC RN Strategies to Mitigate Risk

- Be attentive and *scan* environment:
- ✓ presence of others such as gang activity
- ✓ drug paraphernalia
- ✓ unsecured weapons
- ✓ unsanitary living conditions and odors
- ✓ Heavy-duty locks and chains on doors

- Case conferences

- In-depth training with law enforcement

- Mandatory security or police escort in high-risk areas

- Organizational *"Zero Tolerance"* policies, processes, and positions *"to filter"* and to screen for a *"red flag"*

- Patient-Provider Contracts

Additional HHC RN Recommendations

Topics for academic and continuing education:
- substance abuse
- family dynamics
- psychiatric diagnoses
- domestic abuse
- culture awareness
- simply a better *"way"* to *"talk to people"*

Formal training on potential triggers of angry patients (and caregivers) and research-supported strategies to defuse these types of encounters

Multidisciplinary case conferences that included opportunities for peer support

Supportive leadership and non-punitive culture

Interconnecting Theme

Each HHC RN reported at least two in-home encounters that did not go well

"*Most of the time I expect that they are going to go well. I'm not looking for things to not go well. Until they don't.*"

"*It's not your fault. Don't feel bad. That doesn't usually happen. If it happens to you all the time well then maybe you need to...(laughing) think about your career choice.*"
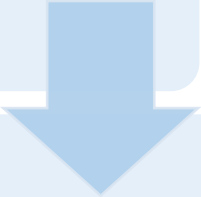
Acknowledging Not All Nurse–Patient Encounters Will Go Well

"*Nothing worse than seeing someone in pain and everyone hates you in the room...you never can take it personally because...you know it's multifactorial.*"
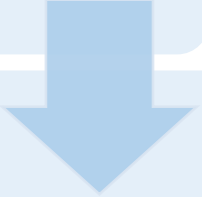
"*The patient, for their own reasons wasn't able to walk down a path of a partnership for health, and so be it.*"

Comparison to Literature

An important finding early in this study was that the terms *difficult patient* and *difficult encounter* were not generally used by study participants

Similar to the findings of others, the term *difficult* was perceived as vague (Simon, Dwyer, & Goldfrank, 1999) and judgmental (Sellers et al., 2012)

Three types of encounters derived from the descriptions of HHC RN interactions with patients and caregivers in this study are proposed

Types of Encounters

A **constructive encounter** is when two or more human beings—the nurse, on the one side, and the patient, caregiver, or both, on the other—interact to achieve a mutually agreed-upon outcome

A **non-constructive encounter** is when one or more human beings (patient or caregiver) obstruct efforts to achieve at least one positive outcome

A **destructive encounter** is when one or more human beings (patient or caregiver) direct anger at or physically aggress toward another human being

Comparison to Literature

Travelbee (1971) proposed rapport as the goal of the original encounter and the final phase of the human-to-human relationship

In this study, the majority of nurse-patient encounters were reported to go well, but *rapport* as proposed by Travelbee (1971) was not the goal or outcome for every encounter

Comparison to Literature

One-time and brief encounters have been identified by nursing (Brown, 2011; Crawford & Brown, 2011; Macdonald, 2007) and mental health (Sellers et al., 2012) as being associated with encounters that do not go well

In this study, several HHC RNs described incidents of anger and sexually inappropriate behavior by patients or caregivers that occurred during subsequent encounters

Comparison to Literature

Wiman and Wikblad (2004, p. 428) explored caring and uncaring nurse-patient encounters in a Swedish emergency room and concluded that *"nurses behaviour does not correspond to any of the theories that stress a relationship as a prerequisite for good nursing"*

In this study, at a minimum a *"working relationship"* or the slightest evidence of reciprocality was needed to achieve at least *"a small goal"*

Comparison to Literature

OSHA, CDC and NIOSH, TJC, and ASIS have created guidelines, standards, and recommendations on the topic of workplace violence and prevention (American Nurses Association [ANA], 2015; ASIS, 2010; McPhaul & Lipscomb, 2004
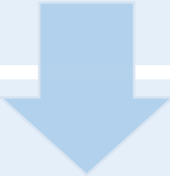
Many states have passed legislation to *"establish or increase penalties for assault of nurses,"* and some states have mandated employers to offer education on workplace violence (ANA, 2015, paragraph 2, sentence 5)
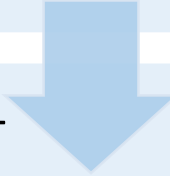
At a minimum, it has been recommended that nurses should be taught to protect themselves if a patient encounter is perceived to be escalating toward a violent interaction (NACNEP, 2007)

In this study, some HHC RNs placed themselves at risk trying to reconcile issues in encounters even when there was zero reciprocity and the patient or caregiver was assessed as not listening

Zero Tolerance Policies were described as effective by some HHC RNs but others perceived *"zero tolerance"* as *"more [of] a facility...driven term"*

In this study, HHC RNs who described supportive and non-punitive cultures were more empowered to *"bring it forward"* and seek guidance with anticipated or actual non-constructive nurse-patient encounters

Implications for Future Nursing Research

- Broadening the understanding of non-constructive encounters and devising strategies HHC RNs can use to prevent, de-escalate, or terminate a patient encounter safely

- Exploring communication and system failures to minimize potential triggers of patient and caregiver anger

- Developing programs with embedded mental healthcare workers along the continuum of care to increase opportunities for direct patient and caregiver access

Study Limitations

- Range in age and RN experience but not gender and ethnicity

- Organizational leadership may have been selective to whom they forwarded the study invitation

- Limited generalizability because of the study design and geographic restriction on data collection

- Common culture shared by many who reside in CT, MA, and RI

Conclusion

- There was a preference for objective and non-judgmental language to communicate outcomes of nurse-patient encounters

- Three types of HHC RN-patient interactions emerged from the data, with constructive encounters the norm and non-constructive or destructive encounters less frequent

- Strategies to promote reciprocality are routinely employed during HHC RN-patient encounters, but HHC RNs who miss cues that a strategy is ineffective or failed may be at risk in the home

- Study data lend support to key concepts, assumptions, and propositions of Travelbee's (1971) Human-to-Human Relationship Model

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DISSEMINATION PLAN

The primary description of this dissertation work was submitted as a manuscript on June 14, 2016 to *Advances in Nursing Science* for review and consideration for publication.

APPENDIX A
STUDY INVITATION

Hello. My name is Mary Kate Falkenstrom. I am a registered nurse (RN) who worked in home health care for over 17 years. Currently I am a doctoral student at University of Massachusetts Worcester. I am inviting you to participate in a research study because you are a RN with home care experience. I would like to interview a diverse group of home healthcare RNs to hear the nurse's perspective of specific patient encounters in the home settings. The purpose of this study is to describe encounters between nurses and patients from the point of view of home healthcare RNs, uncover patient behaviors that may suggest an encounter is not going well, and find strategies home health care RNs feel are effective in responding to these patient encounters. You will not be asked about patient protected health information, as defined by the Health Insurance Portability and Accountability Act (HIPAA). The interview will last approximately 60-90 minutes. Your participation is voluntary and I will not share the names of anyone who participated in the study. All interviews are confidential.

If you are a RN who is 18 years or older, who currently or previously worked in home healthcare, and understands, speaks, and writes English, I welcome the opportunity to speak with you about your home healthcare nursing experiences. Please contact me at mary.falkenstrom@umassmed.edu or by telephone at 508-484-3499 if you are willing to participate or have questions about the study. This research has been reviewed and approved by the UMMS Institutional Review Board.

Thank you-Mary Kate Falkenstrom, RN

STUDY FACT SHEET ONE-ON-ONE INTERVIEW

UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL
COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS IN RESEARCH
FACT SHEET

A. You are invited to participate in a research study called Exploratory Study of Nurse-Patient Encounters in Home Healthcare (HHC).

B. The purpose of this study is to describe encounters between nurses and patients from the point of view of the HHC registered nurses (RNs), uncover patient behaviors that may suggest an encounter is not going well, and find strategies HHC RNs feel are effective in responding to these patient encounters.

C. Your participation in the research will consist of 1 interview in person and possibly 1-2 additional follow-ups in person or by telephone to obtain clarification or further explanation about something you said in the initial interview or to ask about a topic not covered in the initial interview that emerged as important during the course of the study. Your participation may last up to 12 months if I need to re-contact you after the initial interview.

D. As part of this study, you will be interviewed in a private setting of your choice. You will be asked about patient encounters in the home setting that you felt did not go well and also to complete a demographic data sheet. You will not be asked about patient protected health information, as defined by the Health Insurance Portability and Accountability Act (HIPAA). The interview will last approximately 60-90 minutes. With your permission, interviews will be digitally recorded. There will be no cost to you for being in this research study except your time and the cost, if any, of getting to and from the interview site.

E. One of the risks of being in this study is a loss of your personal information. This is very unlikely to happen, and we will do everything to make sure that your information is protected. Some nurses may experience some emotional distress at being asked to describe their experiences and feelings. You will be provided information on counseling services and you can follow-up if you feel the need to talk to someone about how you are feeling.

F. Participation is voluntary. You do not have to be in the study. If you decide to take part, you can choose not to answer any given question and you can decide to quit or discontinue the initial or follow-up interviews at any time. In either case there are no penalties.

G. Efforts will be made to limit access to your personal information to only people who have a need to review this information. We cannot promise complete privacy. The UMMS Institutional Review Board and other representatives of UMMS may see your information.

H. If you have any questions, concern, or complaints, or think that the research has hurt you, you can talk to the principal investigator MARY KATE FALKENSTROM by phone at 508-484-3499 or via email at mary.falkenstrom@umassmed. This research has been reviewed and approved by an Institutional Review Board. You can reach them at (508) 856-4261 or irb@umassmed.edu if you would prefer to speak with someone not associated with the study or have questions about your rights as a research subject.

APPENDIX C
INTERVIEW GUIDE

Topics to be explored during one-on-one interview were drawn from the nursing, medical, and service industry literature. Each interview will develop organically and new topics that emerge will be explored.

1. Reflect upon your experiences as a home health care nurse and tell me about a home visit with a patient that did not go well? What do you think contributed to the outcome of this encounter? (Explore specific characteristics of patient, initial contact by phone, home environment, and time/day of visit if not offered). Was this patient encounter (interaction) the worst you can recall? If not, tell me about your worst patient encounter (interaction) (Explore specific characteristics, similarities, differences in patient, home environment, and time frame if not offered). How did you respond to the patient? (Explore if not shared for (a) techniques and strategies to diffuse or de-escalate the encounter? (b) What were the RN's priorities at the time? What did you do? How did you feel? What did you do next? How do you think you handled the situation? How did this experience affect how you responded or handled similar situations in the future?

2. What else would you like to share about these particular encounters? What suggestions might you have for another nurse who had a similar encounter or experience and what to do should one occur? (Explore if not shared for (a) how did this encounter differ from encounters that the RN perceived to have gone well or had a positive outcome? (b) How does the RN connect, develop relationships, rapport, and get to know patients? (c) How does RN gets patient to know RN?

3. Have you ever had any training or education to prepare you for encounters in the home that have the potential or do not go well? What, if anything, have you found to be the most helpful?

4. One final question, is there a term that you use to identify or label these types of encounters? How would you define that term? (Repeat phrases used by interviewee and ask why the interviewee used a particular phrase and if there were other ways the interviewee would describe encounters that did not go well?)

APPENDIX D
DEMOGRAPHIC DATA FORM

Please answer the following questions. All of your responses are confidential.

1. Years licensed as a Registered Nurse (RN)? _____

2. Years worked as a Home Health Care RN? _____

3. Employment status in Home Health Care?

   Not Working ☐   Full Time (36-40 HR/WK) ☐ Part Time (24-32HR/WK) ☐

   Per Diem☐ (Include HR/WK _____ and Total HR Worked/Past 3Months_____)

4. Is Home Health Care your primary position (Please Check)? Yes ☐ No☐

5. If working in Home Health Care, present Job Title? _____

6. If working in Home Health Care, other past Job Title (s)?_____

7. If not working in Home Health Care, past Job Title(s)? _____

8. Type of home healthcare organization employed or previously employed (Check all that apply)? Multidiscipline Home Care Organization ☐Hospice ☐High-Tech Infusion and Enteral Nursing Agency ☐

9. Size of home healthcare organization employed or previously employed (Check all

   that apply)? Local 10-15 communities ☐State ☐National ☐

10. Other RN position(s) presently held?_____

11. Past RN positions and years worked? (Please check all that apply and specify

    Unit/Setting if applicable)

☐Ambulatory Care/Clinic: _____

☐Academia:_____

☐Hospital:_____

☐Industry:_____

☐Physician Office: _____

☐Public Health:_____

☐School System:_____

10. Highest Educational Degree Earned in Nursing:

Diploma ☐   AD ☐   BSN ☐   MSN ☐   PhD in Nursing ☐

11. Other Non-Nursing Degrees? _____

12. Age: _____

13. Gender (Please check): Female ☐   Male ☐

14. Describe Race/Ethnicity: _____

15. Have you experienced a Patient Encounter that did not go well in the past week _____
 month ____ 12 months _____ OR it has been _____years since I had an encounter that did
not go well.

16. How many Patient Encounters have you experienced that have not gone well in the
past week_____; month ____ ; 12 months _____ (Please enter total number for each time
period).

Coding (To be completed by nurse researcher) Pseudonym:	Date:

APPENDIX E
LIST OF PSEUDONYMS

Top 100 names of the year 2013 retrieved from http://www.babycenter.com/top-baby-names-2013

Girls' Names	Boys' Names
1. Sophia	1. Jackson
2. Emma	2. Aiden
3. Olivia	3. Liam
4. Isabella	4. Lucas
5. Mia	5. Noah
6. Ava	6. Mason
7. Lily	7. Jayden
8. Zoe	8. Ethan
9. Emily	9. Jacob
10. Chloe	10. Jack
11. Layla	11. Caden
12. Madison	12. Logan
13. Madelyn	13. Benjamin
14. Abigail	14. Michael
15. Aubrey	15. Caleb
16. Charlotte	16. Ryan
17. Amelia	17. Alexander
18. Ella	18. Elijah
19. Kaylee	19. James
20. Avery	20. William
21. Aaliyah	21. Oliver
22. Hailey	22. Connor
23. Hannah	23. Matthew
24. Addison	24. Daniel
25. Riley	25. Luke

APPENDIX F
STUDY FACT SHEET INTERPRETIVE FOCUS GROUP

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C. Your participation in the research will consist of 1 focus group and possibly 1-2 additional follow-ups in person or by telephone to obtain clarification or further explanation about something you said during the focus group. Your participation may last up to 12 months if I need to re-contact you after the initial focus group.

D. As part of this study, you will participate in a focus group in a private setting. You will be asked about patient encounters in the home setting and also to complete a demographic data sheet. You will not be asked about protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA). The focus group will last approximately 60-90 minutes. With permission of each focus group member, the group's discussion will be digitally recorded. There will be no cost to you for being in this research study except your time and the cost, if any, of getting to and from the focus group site.

E. One of the risks of being in this study is a loss of your personal information. We will do everything to make sure that your information is protected. There is the potential you may know or another participant in the focus group may know you. To respect each participant's privacy, identities and conversations during the focus group are to be kept confidential. Some nurses may experience some emotional distress at being asked to describe their experiences and feelings. You will be provided information on counseling services and you can follow-up if you feel the need to talk to someone about how you are feeling.

F. Participation is voluntary. You do not have to be in the study. If you decide to take part, you can choose not to answer any given question and you can decide to quit the focus group or discontinue follow-up contact at any time. In either case there are no penalties.

G. Efforts will be made to limit access to your personal information to only people who have a need to review this information. We cannot promise complete privacy. The UMMS Institutional Review Board and other representatives of UMMS may see your information.

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APPENDIX G
COUNSELING SERVICES

 All study participants will be provided a web address to locate a therapist within a convenient geographical location should they feel the need to talk to a professional about their experiences or feelings. (http://www.psychologytoday.com/)

> If you feel it would be helpful to talk more about your experiences go to the Psychology Today website (http://www.psychologytoday.com/) to privately select a therapist by zip code and review the therapist's profile.