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Quality Nursing Care for Hospitalized Patients with Advanced Illness: Concept Development

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Abstract

The quality of nursing care as perceived by hospitalized patients with advanced illness has not been examined. A concept of quality nursing care for this population was developed by integrating the literature on constructs defining quality nursing care with empirical findings from interviews of 16 patients with advanced illness. Quality nursing care was characterized as competence and personal caring supported by professionalism and delivered with an appropriate demeanor. Although the attributes of competence, caring, professionalism, and demeanor were identified as common components of quality care across various patient populations, the caring domain increased in importance when patients with advanced illness perceived themselves as vulnerable. Assessment of quality nursing care for patients with advanced illness needs to include measures of patient perceptions of vulnerability.

Keywords

quality of nursing care; concept development; advanced illness; vulnerability

As concerns about the quality of healthcare have spread, there have been increasing interests and efforts to evaluate and improve quality in healthcare and nursing (American Nurses Association [ANA], 1999; Institute of Medicine [IOM], 2001). As part of those efforts, several indicators have been developed to measure quality of hospital nursing care (Aiken, Clarke, & Sloane, 2002; ANA, 2006; Gallagher & Rowell, 2003). The ANA (1999) developed a set of nurse-sensitive quality indicators that was used to develop the National Database of Nursing Quality Indicators (NDNQI) for unit-level assessment and cross-unit comparisons of nursing quality (ANA, 2006; Gallagher & Rowell). The NDNQI includes variables such as patient fall rate, pressure ulcer incidence, nosocominal infection rates, nurse skill mix, and nursing hours per patient day. In Donabedian's structure-process-outcome framework for quality of care (Donabedian, 1966), these nurse-sensitive indicators include structure and outcome, but not process variables.

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Although nurse-sensitive indicators are useful to demonstrate how the structure of nursing care relates to healthcare outcomes, thus providing data to make structural changes to improve negative outcomes, they reveal little about what quality nursing care is. As Donabedian (1988) pointed out, it is critical to have measures to evaluate the process of nursing care in addition to structure and outcome indicators (Needleman, Kurtzman, & Kizer, 2007). Yet, there is a gap in the literature about indicators of the quality of the nursing care process and how to measure them. The purpose of this study was to identify attributes to evaluate the quality of the nursing care process for hospitalized patients with advanced illness.

The current literature on the evaluation of quality nursing care not only lacks a focus on process but the perspective of the patient also is largely missing. Patients are legitimate evaluators of care quality as direct recipients of the care. However, traditionally patients are viewed as incapable of evaluating or not knowledgeable enough to evaluate the care they receive (Rosenthal & Shannon, 1997). Meanwhile, an increasing emphasis on the importance of patient-centered care (IOM, 2001), market forces, and financial incentives has prompted hospitals to treat patients as service clients, and over the last decade patient satisfaction has become a key quality indicator (Kutney-Lee, Lake, & Aiken, 2009). Although patient satisfaction is an important input from patients regarding the care they receive, several researchers have argued that patient satisfaction itself is conceptually inadequate as a quality measure (Aspinal, Addington-Hall, Hughes, & Higginson, 2003; Jennings & Staggers, 1999; Lin, 1996). Patient satisfaction is the extent to which the patient's expectations are met in the care provided; thus, if a patient does not expect much, he or she may be satisfied regardless of the quality of care provided (Redman & Lynn, 2005). It may be more critical, therefore, to know what patients consider essential to quality nursing care and what their expectations are than whether or not they are satisfied (Lynn, McMillen, & Sidani, 2007).

A number of researchers have explored what patients consider quality nursing care and their expectations of nursing care (Larrabee & Bolden, 2001; Oermann, 1999; Radwin, 2000). The findings from these studies suggest multidimensionality and diversity in defining quality nursing care across different patient groups. Because definitions, dimensions, and priority among attributes differ depending on the patient group, Stichler and Weiss (2001) recommend targeting subsets of patient groups rather than treating all patients as a homogeneous group. Jennings and Staggers (1999) suggested a population-based approach, segmenting patients by key characteristics as a critical and meaningful method for defining quality indicators.

Patients' expectations and evaluations of quality nursing care also depend on patient characteristics such as age, sex, education, and the type and stage of illness (Mitchell, Ferketich, & Jennings, 1998; Radwin, 2002; Redman & Lynn, 2005). Yet, investigations of variation in perceptions of quality nursing care among different patient groups are scarce (Radwin, 2002). Because of extended experiences with illness and healthcare services, patients with advanced illness may be a group that has different views, needs, and expectations about quality nursing care than patients who are hospitalized for an acute illness. Although patients with advanced illness form a substantial part of the patient population in many hospitals (Wennberg, Fisher, Goodman, & Skinner, 2008), their perspectives on quality nursing care are largely lacking in the literature.

Our goal is the development of an instrument to measure quality of nursing care process from the perspective of hospitalized patients with advanced illness. In this paper, the authors report the results of efforts to delineate the conceptual underpinnings of a future instrument. The specific aim of this phase of instrument development was to define the concept of

quality nursing care and identify its attributes from the perspective of patients with advanced illness, integrating findings from the literature with empirical findings from interviews.

Method

Design

The hybrid model of concept development elaborated by Schwartz-Barcott and Kim (2000) was chosen to guide concept development, with a focus on developing a definition based on specific measureable attributes. The model emphasizes the integration of theoretical knowledge and empirical data and is comprised of three phases: theoretical, fieldwork, and analytical.

Theoretical Phase

The concept of inquiry was *quality nursing care* from the perspective of hospitalized patients. The goal of the theoretical phase was to gain a comprehensive understanding of the literature dealing with the concept (Schwartz-Barcott & Kim, 2000). A literature search was conducted using the Cumulative Index to Nursing and Allied Health Literature, MEDLINE, and PsycINFO databases; key words included *quality of nursing care* and *quality of health care* plus *nursing*. The search was limited to adult subjects and journal articles in English. The date range for the initial search was 1990 to 2008, because the conceptualizations of quality care before 1990 were judged not to be applicable to the current healthcare system due to healthcare reform in the 1980s. Articles identified (N=785) were screened by title, then by abstract, to exclude irrelevant articles, such as clinical trials of medical treatments and studies not including hospital nursing care. For 185 articles meeting the inclusion criteria, reference lists were searched for additional relevant publications, and key literature before 1990 identified from the reference lists was reviewed to trace the historical development of the concept of quality care in nursing. The literature search continued through the fieldwork and analytical phases as new insights emerged.

Fieldwork Phase

Fieldwork interviews were conducted in an urban acute care teaching hospital in the Pacific Northwest region of the U.S. Patients admitted to the hospital with advanced-stage illness were identified using the following criteria: having stage IV (solid organ or hematologic) cancer, end-stage chronic lung disease, and/or organ (renal, heart, or liver) failure. Inclusion criteria were ≥18 years of age, English-speaking, hospital stay of ≥3 days, and more than two previous hospital admissions in the last 12 months.

Maximum variation sampling strategy (Patton, 2002) was used to include a broad spectrum of patients to assure identifying themes across demographic variations. Five demographic characteristics (age, sex, education, race/ethnicity, and reason for hospitalization) were anticipated to be relevant to perceptions of quality care (Chang et al., 2003; Cleary & Edgman-Levitan, 1997; Hancock et al., 2003); variations in these characteristics were sought during recruitment. After Institutional Review Board approval was obtained, potential participants who met the criteria were identified by care managers in adult hematology-oncology, cardiac, intensive care, and medical-surgical units in the hospital. The care managers distributed invitation letters to eligible patients, and interested patients contacted the researcher to schedule an interview. Before the interview patients signed an informed consent. Data were collected between April and September 2008.

Based on literature reviewed during the theoretical phase, a semi-structured interview guide was developed. The primary question was “Would you please describe what you think is

good quality nursing care?" Participants were encouraged to talk about experiences of nursing care that they thought indicated presence or absence of quality. At the end of interview, participants were asked to comment on how quality indicators identified in the literature (e.g., safety, feeling cared for, teaching) related to their ideas of quality nursing care, if they had not already discussed these during the interview. Interviews were audio-recorded in patients' hospital rooms.

Responses were analyzed using qualitative content analysis (Hsieh & Shannon, 2005; Sandelowski, 2000). Recorded interviews were transcribed verbatim, and transcripts were reviewed and open-coded using QSR NVivo8 (QSR International; Doncaster, Victoria, Australia) with terms representing the essence of descriptions. Codes with similar properties and functions were grouped as indicators of key attributes of quality nursing care, and attributes were in turn grouped into domains. The domains were considered the underlying dimensions of the concept of quality care. Codes, attributes, and domains were modified as new data or insights about their meaning were incorporated into the analysis.

Saturation of data was confirmed when the last three interviews did not add new codes, attributes, or domains. Ongoing member checking was conducted informally by asking for clarification and elaboration of meanings during interviews (Sandelowski, 1993).

Analytical phase

Findings from the theoretical and fieldwork phases of the study were integrated into a conceptualization of *quality nursing care*. In this process, domains and their attributes identified from the fieldwork phase were compared and contrasted with theoretical phase findings to confirm, add to, or modify the concept of quality nursing care for patients with advanced illness. In addition, the accounts in the field work interviews that appeared to be unique to patients with advanced illness were further examined contextually to explore the possibility of attributes of quality nursing care unique to this population.

Results

Theoretical Phase Findings

Despite the frequent use of the term *quality* in the nursing literature reviewed, the term lacked clear definition and explicit criteria (Attree, 1993; Gunther & Alligood, 2002; Lynn et al., 2007). Quality was thought to be complex and multidimensional, but what it meant varied depending on the context (Chance, 1980; Currie, Harvey, West, McKenna, & Keeney, 2005). The concepts *quality of care* and *patient safety* were often addressed together (ANA, 1999; Loan, Jennings, Brosch, & DePaul, 2003), implying that *quality* and *safety* were viewed as a single issue. Articles using *quality* as a key word and attempts to measure quality often focused on patient *safety*, and used safety measures (e.g., fall rates, nosocomial infection rates) as indicators of quality. The concept of *safety* was added to fieldwork interview questions to ascertain patients' perspectives about the relevance of safety to quality nursing care.

Definitions and models—Authors who have attempted to define quality in nursing care (Chance, 1980; Wandelt & Stewart, 1975; Zimmer, 1974) have identified it as a characteristic or attribute of excellence within the context of degree of merit desired and valued in society. However, their definitions lack concrete descriptions of attributes constituting quality nursing care. More recently, Larrabee (1996) and Attree (1996) developed theoretical models of quality care. Both models were theory-driven, but conceptualized quality of healthcare in general. Specific attributes for quality nursing care were not identified.

Donabedian's (1980) definition of quality care was often cited in the nursing literature. Although his model focuses on health care, not nursing care, his definition of quality of care that individual practitioners provide to individual patients was useful in defining quality of nursing care at the individual versus organizational level. Donabedian identified technical and interpersonal aspects of care as the basic elements of quality. Technical care referred to scientific care, applying professional knowledge and skills to benefit the patient's health and minimize risks. Interpersonal care was viewed as the "art" of care, including development and management of patient-practitioner relationships. He also considered "amenities" as a third element of quality of care, yet concluded that they were instead part of the management of the interpersonal relationship signifying the practitioners' concern for patient comfort.

Wilde, Starrin, Larsson, and Larsson (1993) developed a model of quality of health care from a patient perspective using a grounded theory approach. In this model, quality of care consisted of two components: the resource structure of the care organization and the patient's preference. The resource structure included the quality of the physical and administrative environment and practitioner-related qualities. Similar to Donabedian's definition, Wilde et al. (1993) indicated that practitioner-related qualities included both medical-technical competence and personal relationships.

Descriptions of quality care attributes—Although explicit and broadly accepted definitions or models of *quality nursing care* were not found in the literature review, we did find studies in which a broad range of attributes of quality nursing care from patients' perspectives were explored. Investigators sometimes used different terms (e.g., excellent, good) as synonyms for *quality* care.

Elements of quality nursing care identified from studies using empirical analyses of data from patients could be categorized broadly into cognitive and technical competence, and affective or interpersonal skills. Cognitive competence included scientific, psychosocial, and personal or experiential knowledge, cognitive skills of assessment and decision-making, and effective psychomotor skills (e.g., Oermann, 1999; Radwin, 2000; Redman & Lynn, 2005). Although technical competence was identified as an essential element of quality care by professional nurses, patients tended to assume these skills would be present (Coulon, Mok, Krause, & Anderson, 1996; Larrabee & Bolden, 2001; Thorsteinsson, 2002). Patients also identified affective dispositions such as empathy, caring, and good personal demeanor as elements of quality care (Åstedt-Kurki & Haggman-Laitila, 1992; Larrabee & Bolden; Price, 1993). Good communication skills and interpersonal competence also were identified by patients as key elements of quality care because they promoted individualized care and established good nurse-patient relationships (Coulon et al., 1996; Radwin & Alster, 1999).

Instruments to measure quality of nursing care—Although numerous instruments relating to quality of nursing care exist, most measure patient satisfaction instead of quality, were developed without including patients' perspectives, and/or lack psychometric assessment (Lynn et al., 2007). Several instruments do measure the quality of nurses' practice based on patients' perspectives. Dozier, Kitzman, Ingersoll, Holmberg, and Schultz (2001) developed the Patient Perception of Hospital Experience with Nursing (PPHEN) to measure patients' perceptions of the degree to which their needs are met during hospitalization. Fifteen items were derived from Swanson-Kauffman's (1988) theoretical framework of caring, which was developed from the perspectives of parents who experienced miscarriage. Although the PPHEN demonstrated adequate psychometric properties, the lack of validation with diverse patient groups and the unidimensional conceptualization limit general applicability of this instrument.

The Quality from the Patient's Perspective (QPP) Questionnaire was developed based on a model of quality of care derived from a grounded theory study of patients with infectious disease conducted by the same researchers (Wilde, Larsson, Larsson, & Starrin, 1994). The QPP Questionnaire consists of 61 items in four dimensions as described in their model (Wilde et al., 1993): the physical-technical conditions of the care organization, the socio-cultural atmosphere of the care organization, medical-technical competence of the caregivers, and the degree of identity-orientation in attitudes and actions of caregivers. The QPP demonstrated acceptable reliability, but no test for validity was reported (Larsson & Larsson, 1999).

Lynn et al. (2007) developed the Patient's Assessment of Quality Scale —Acute Care Version (PAQS-ACV) based on interviews with patients from a variety of medical surgical units. Multiple steps of validation and testing resulted in a 44-item questionnaire with five factors: individualization, nurse character, caring, environment, and responsiveness. The PAQS-ACV demonstrated satisfactory reliability and content and construct validity. Lynn et al. pointed out that studies to establish norm criteria of the PAQS-ACV for particular groups of patients are necessary.

Radwin, Alster, and Rubin (2003) developed the Oncology Patients' Perceptions of the Quality of Nursing Care Scale (OPPQNCS) consisting of 40 items (or 18-items in a short form) in four dimensions: responsiveness, individualization, coordination, and proficiency. This scale was based on a qualitative study of oncology patients' perceptions of the quality of nursing care (Radwin, 2000). The scale has good reliability, and construct validity was assessed using factor analysis.

These instruments developed to measure quality of nursing care from patients' perspectives contain both cognitive/technical and affective/interpersonal aspects of care reflecting theoretical and empirical descriptions of quality nursing care. Yet, it is noteworthy that these empirically developed instruments often include some other dimensions or factors besides nurses' cognitive/technical competence and affective/personal caring (e.g., responsiveness, nurse character, or environment). It suggests the multidimensionality of the concept of quality nursing care beyond the competence-caring dichotomous view of nursing care.

Fieldwork Phase Findings

Sixteen patients who met inclusion criteria were interviewed. Participants included 8 men and 8 women ages 24 to 85 years (M = 54.9, SD = 19.3), who were primarily Caucasian (n = 12, 75%; 1 Latino, 2 African American, and 1 mixed-race). All had graduated from high school, and the majority (n = 15, 93.8%) had some college education. Participants described the reason for their hospitalizations as symptom management or treatment for a specific problem (e.g., bleeding, infection). Mean interview time was 38 minutes (SD = 16.3).

Based on the analysis of interview data, 97 codes describing quality of nursing care were generated and grouped into four domains: competence, caring, professionalism, and demeanor (Table 1). One group of accounts described how the participants felt as a result of receiving quality nursing care. They were coded as "outcomes" and used to contrast quality care from non-quality care, but they were not included as attributes of quality nursing care.

Competence domain—This domain represents nurses' cognitive and technical abilities to provide adequate care to patients. Absence of these abilities was described as poor quality care. Descriptions of abilities in this domain formed the largest part of the interview data, indicating that competence was an indispensible part of quality nursing care.

Participants described competent nursing care as meeting everyday needs (e.g., assistance for toileting, meals, controlling environment); treatment-related needs (e.g., safe and punctual delivery of treatment, pain management); and need for information (e.g., explanation about medications and treatment). Participants reported that addressing their individual needs required attentiveness on the part of the nurse. Fourteen participants mentioned timely responses to their needs as an important aspect of competent care. Although participants acknowledged that nurses were busy, they described quality nursing care as fulfilling their needs within a reasonable timeframe according to the urgency of the situation.

Participants described a competent nurse as knowledgeable about: the illness and treatments; how these affected their bodies and lives; preventing or minimizing negative treatment/condition effects; and their individual needs. Nurses who were perceived as not knowledgeable made patients uneasy. The care by these nurses, participants said, was neither efficient nor safe. One participant reported that nurses on the unit were not familiar with her diagnosis and did not know the nature of pain caused by her disease. She concluded the nurses' care was not competent because they lacked adequate knowledge about how to manage her pain. On the other hand, another participant praised a nurse who knew about his "jumpy legs" and was knowledgeable about how to guide him to move around without falling.

Participants also thought competence meant being technically skillful. They valued nurses who were skilled in giving injections, inserting intravenous lines, and doing medical procedures without causing unnecessary pain. Good skills also were described in terms of efficient and safe transfer and tactful handling of excretion and hygiene to avoid causing embarrassment and discomfort.

Competent nurses explained what they were doing and provided information about the patient's illness and treatment. Although few participants used the term patient education as part of quality nursing care, most (n = 12) said that it was important for nurses to provide information about medications and treatments they were giving and to answer patients' questions.

Participants said nurses' competence in communicating effectively with healthcare team members promoted smooth treatment and quality care. One person said that she would not receive adequate pain management if her nurses were reluctant to call her physicians, and five thought nurses working collaboratively and conferring with each other would increase safety and improve care quality.

Caring domain—Caring was described as genuine concern and compassion for patients as fellow humans. Ten participants described quality nursing care as being treated in a way that indicated the nurse cared for patients as people, not as objects of their work. Eight participants described caring nurses as those who visited patients, spent extra time, and talked with them about their lives beyond disease and treatment. They reported appreciating a person-to-person relationship with the nurses.

For some, caring was going above and beyond duties to reach out to patients. One participant talked about a nurse who spent more than half an hour encouraging her not to give up when she was depressed about a newly diagnosed cancerous tumor. Another participant with cancer appreciated a nurse who visited him after her shift and disclosed her personal experience with a cancer diagnosis and chemotherapy. He thought she "went the extra mile" sharing her personal experience to reach out to him. Another appreciated the "human touch" from a nurse:

> When I could not breathe, and the blood was just pouring out of me, he [the nurse] put his arm around my shoulder and just gave it a little squeeze and told me "It will be okay." The way he did it was like he would do to his mother or his sister or his grandma or something. It was very touching. And when you are so sick, you do need that human touch. (Caucasian, 62 year old, woman)

This participant said that the caring human touch was unexpected, but it was just the excellent care she needed at that time.

Professionalism domain—Four participants used the term "professional" or "pro" to describe a critical component of quality nursing care. Fourteen mentioned conduct or attitudes that were characterized as professionalism: being responsible, autonomous, and committed. Several said they felt reassurance and comfort when nurses visited at the beginning of a shift and let them know who would be responsible for their care. They liked nurses who did what they promised and did what the patient thought nurses were responsible to do. One participant described care as poor because the nurse forgot his request for water many times and failed to make sure meals were received.

One participant described quality nursing care as requiring nurses to function as autonomous and responsible professionals. He expressed frustration about the low quality care he received from a nurse.

> I was shivering, and she [the nurse] said she didn't have the Tylenol and waited for an order from the doctor. I said, "I have Tylenol here. Let me just take it." She said, "No. You can't use your own." So in the meantime, I was a mess. That decision should be overridden by a nurse. If you have got the Tylenol, take the Tylenol. Or call the doctor and say "I am not going to wait. This man needs Tylenol. He needs something now." That's what I am talking about. That's professionalism. (Caucasian, 63 year old, man)

Willingness to work was another professional attitude participants described. They said that nurses who were not willing to work —"just putting in their time" or working only when someone was watching over their shoulder —were not providing high quality nursing care. Nurses willing to work and take care of patients were described as welcoming patients and their requests. Ten participants said that nurses who provided quality care looked like they enjoyed what they did and were willing to do things for patients. Willingness to exert effort on the patient's behalf was seen as an important element of quality nursing care.

Self-discipline and control of their behavior was another professional attitude participants expected of nurses. Although they valued a personal relationship with nurses, they thought it was unprofessional for nurses to complain about personal problems, colleagues, or other patients in front of patients. They appreciated nurses who maintained a professional appearance and attire, and did not show negative feelings, such as disgust, frustration, or displeasure while providing care.

Participants said nurses who were willing to learn and continuously strive to improve themselves provided quality care. They appreciated nurses who were willing to learn from patients how to do a better job. One thought a nurse put her at the risk of heart failure because the nurse did not listen to her explanation about her normally low blood pressure and her way to deal with it.

Two participants mentioned that being truthful to patients and providing fair treatment were part of quality care. They wanted to have honest explanations about conditions and treatments, especially when something went wrong. They also wanted to be treated fairly regardless of their diagnosis or conditions. One participant talked about fair treatment in

terms of power differences between nurses and patients. According to her, patients were in a hospital because they needed nurses' care, thus nurses who were condescending to or bullying patients who had to depend on them were unfair and unprofessional.

Demeanor domain—The demeanor domain reflects how nurses appear and present themselves to patients rather than what they do for patients. Participants' impressions of the nurse's demeanor affected how they perceived the quality of care the nurse provided. Perceptions of positive demeanor (e.g., friendly, respectful, confident) made participants feel they received good and competent care; whereas negative demeanor (e.g., cold, mean, "frazzled") made them feel the care was inferior, even though it might have been appropriate.

When describing good quality nursing care, some participants admitted that they could not be sure if a nurse was actually competent, caring, or professional. However, based on the nurse's demeanor (such as confident, respectful, pleasant), they evaluated the quality of the nursing care being provided as competent, caring, or professional.

Analytical Phase Findings

Four domains of quality nursing care—Findings from 22 qualitative studies about patients' perspectives of quality nursing care were compared and integrated with findings from the fieldwork (Table 2). Although researchers have categorized the attributes of quality in different ways, themes identified in prior studies also were identified in the fieldwork findings. Attributes of the competence, caring, and demeanor domains were reported in most studies; attributes of professionalism also were found in those studies, but less frequently.

The domains of *competence* and *caring* are comparable to general categories of cognitive/technical and affective/interpersonal skills, respectively. They are identified as two major components of quality nursing care across studies. Most of the attributes of the *demeanor* domain (e.g., kind, friendly, easy to talk, respectful) usually have been grouped as part of the interpersonal aspect of quality care. Although many *demeanor* attributes are elements of interpersonal skills, some attributes such as confidence are more closely related to *competence* than *caring*. Moreover, many of the attributes in the *demeanor* domain involved descriptions of nurses' personality traits rather than the nurses' practice. They implied that to provide quality nursing care, nurses had to have a certain personality traits and demeanor in addition to cognitive/technical and interpersonal skills. Therefore, *demeanor* was identified as a separate domain of quality nursing care in this analysis.

Professionalism also was not identified as a separate domain in most of the studies. In the current fieldwork analysis, many of attributes of the professionalism domain were initially placed in the domains of *competence* and *demeanor* until a few participants used the term "professional" to describe a distinct aspect of quality care. According to these participants, a nurse's care was perceived as quality care when it met the standard of what they expected from a nursing professional. Participants expected nurses to have a certain level of technical skill and knowledge, to be caring, and to have certain personality and demeanor characteristics because they saw nurses as professional. If a nurse's care fell below that standard, it was judged to be of poor quality. For example, the man who described his frustration with not receiving immediate treatment while he was shivering perceived the nurse's care as of poor quality. He expected professional nurses to have the knowledge to make autonomous judgments and the ability to demonstrate empathy for a patient's suffering and to take action. All attributes of quality nursing care identified in the fieldwork interviews and in other studies were undergirded by patients' value of *professionalism*, and professionalism in turn was manifested in quality nursing care as *competence*, *caring*, and

demeanor. Thus *professionalism* was identified as the foundational component of quality nursing care.

Several areas identified as components of quality nursing care in other studies, such as amenities, the hospital's physical environment, number of nursing staff, and administrative organization, also were mentioned in the fieldwork interviews in this study. Although some of these areas were assumed to relate to nurses' *competence* or *caring*, most were not included in the current conceptualization of quality. They were judged to be contextual factors that may have influenced the nursing care, but were not attributes of the direct care provided.

Different manifestation of domains in patients with advanced illness— Similarities in attributes of quality nursing care identified from studies of various patient groups suggest that hospitalized adult patients, regardless of their health conditions, have similar ideas about what constitutes quality nursing care. Furthermore, the attributes identified in this analysis were similar to those found in studies cited above conducted in Europe, Australia, and Asia, providing further evidence of their far-reaching relevance as key attributes of quality nursing care.

This does not mean that patients with advanced illness do not have different perceptions about quality nursing care from those of other patient groups. In her discussion of the concept development process, Morse (1995) noted, "While the abstract and universal components of the concept remain, they need not be manifest identically in each group" (p. 39). To explore the possibility of a unique manifestation of the domains of quality nursing care for patients with advanced illness in contrast to other populations, descriptions of quality nursing care in relation to characteristics of patients with advanced illness were considered.

Because interviews were used to explore patients' perspectives on quality nursing care, all participants in the fieldwork were conscious and physically stable at the time of interview. However, 6 out of 16 participants said that there was a time they thought they were dying during the course of a hospitalization, and all participants said there was a time when they were very ill and felt vulnerable. Participants described these times as "being very sick," "I could not do much [by myself]," "have to have someone [to advocate for me]," and "I have to depend/rely on them [nurses]." For patients who had times when they thought they were dying, vulnerability included not only loss of control and dependency on others but an acute sense of mortality. At these times, participants described themselves as feeling weak, scared, and fearful. Feeling vulnerable in the face of critical conditions or death was an experience many patients with advanced illness shared.

The kind of nursing care that participants described as quality care when they were in vulnerable situations was different from what they described in their accounts of less vulnerable situations. One participant said he needed more emotional support when he was more seriously ill. When the female participant thought she was bleeding to death, she said she felt very weak, vulnerable, and needed someone with her. This patient seemed to be very independent and self-sufficient, and said she did not need that kind of human touch at the time of interview (2 days after the hemorrhage). However, she "needed" the squeeze on her shoulder the nurse gave her when she thought she was facing death. She also appreciated that the nurse, without being asked, advocated for her by reporting to a physician about her condition and urging the physicians to intervene. The participant who was not allowed to take his own Tylenol said that the nurse's care was low in quality because the nurse did not care or show personal concern for him when he was shivering and "scared to death." Throughout his interview, he repeated that *caring* would be nice, but that the most important

component of quality nursing care was *competence*. However, in his story about being vulnerable and frightened, what he described as quality nursing care was the nurse's *caring* and concerns for him as a fragile person.

Domains of quality nursing care were manifested differently when patients perceived themselves to be in a vulnerable state: as vulnerability increased, the caring domain became a more dominant theme. This is similar to the findings of Irurita (1996, 1999), who reported that when the patient is highly vulnerable, *soft-hand* care (i.e., going extra mile to ensure patient comfort, being there for patients, having human touch) was necessary to quality nursing care in addition to *firm-hand care* (i.e., technical competence, facilitating patient independence). In Redfern and Norman's (1999) study, nurses' sensitivity towards patients' emotional needs in relation to their vulnerability was highlighted as a quality indicator. Findings from several other studies with patients who may be assumed to be vulnerable (e.g., oncology patients, med-surg patients with long hospital stays, psychiatric patients) also included more caring components as quality nursing care attributes (e.g., Beech & Norman, 1995; Milburn, Baker, Gardner, Hornsby, & Rogers, 1995; Radwin, 2000) than findings from less vulnerable populations (e.g., Middleton & Lumby, 1999). This suggests that when patients feel less vulnerable, they perceive nurses' caring behaviors as nice but not a necessary component of quality nursing care, but when they feel vulnerable, caring is perceived as an especially critical attribute of quality nursing care.

In addition, different kinds of caring behaviors were described as important in the context of vulnerability. One group of behaviors was nurses recognizing patients as individuals and respecting their autonomy as equal partners (e.g., Haggman-Laitila & Astedt-Kurki, 1994; Radwin, 2000; Wilde et al., 1993). Another was understanding the hardships patients were experiencing and stepping in to reduce the burden for the patient or comfort patients without being asked (e.g., Burfitt et al., 1993; Irurita, 1996; Milburn et al., 1995; Radwin 2000). Participants appreciated nurses respecting their individuality and autonomy as quality care when they felt less vulnerable, but in times of greater vulnerability, nurses stepping in to do things without being asked was viewed as quality care. In both the current study and Irurita's (1996) study of patients with long hospital stays, there were expressions of *doing extra* and *human touch* as caring attributes. Milburn et al. studied medical-oncology patients and identified "an arm around me when I am feeling low or in pain" as psychological care. Burfitt et al. and Radwin (2000) found that patients in intensive care and oncology units perceived mothering or nurturing as caring behavior. Many other researchers have described *caring* in terms of respecting individuality and treating patients as partners. When patients feel more independent and not vulnerable, they may know what they need, be able to choose, and express what they want. When patients feel vulnerable and not in control, they may not be sure what they need or how to ask for it. Therefore, reaching out to respond to patients' unspoken needs was characterized as caring behavior for patients in vulnerable states. Not only the importance of caring attributes, but what kind of caring behaviors are perceived as quality care varied depending on the patient's perception of vulnerability.

Discussion and Conclusions

Quality nursing care from the perspectives of patients with advanced illness was characterized as competent and caring professionalism presented with an appropriate demeanor. Although these universal components of quality nursing care identified in the review of literature and fieldwork demonstrated the four domains across different patients groups, how the attributes of these domains are manifest varied by the perceived vulnerability of patients with advanced illness. Specifically, how much and what caring behavior entailed varied depending on the degree of vulnerability the patient was experiencing. Although vulnerability is not a characteristic solely associated with patients

with advanced illness, and patients with advanced illness are not necessarily always vulnerable, findings suggest that the variation in quality care attributes, particularly the *caring* attribute, depend on patients' perceptions of vulnerability and should not be overlooked when considering quality nursing care for patients with advanced illness. Variations in other domains in relation to the population specific characteristics were not observed in this study.

Although participants highlighted a specific domain or attribute (particularly *caring* attributes) as most important in times of vulnerability, they frequently added that they assumed other attributes were there as well. Thus, whether vulnerability affects other domains and whether the importance of other domains decreases as the caring domain becomes more important in the patient's perception of quality nursing care were not clear from this study. Further studies are needed to explore whether there are characteristics specific and significant to patients with advanced illness other than perceived vulnerability.

These unanswered questions demonstrate the limitations of the study. Because semi-structured interviews were used to explore patients' perspectives, the participants were limited to patients who had advanced illness but were conscious and physically stable at the time of interviews. Their descriptions of quality nursing care when they felt vulnerable were retrospective reflections. Careful consideration should be given when applying the findings to more critically ill patients with advanced illness. Another limitation was that all participants were recruited from a single teaching hospital, which limits generalizability of the findings, even though maximum variation sampling was used and data saturation was achieved. Although integrating fieldwork findings with the literature using the hybrid model adds validity to the findings, further studies are needed to determine if attributes found in this study can be generalized to patients with advanced illness in nonacademic healthcare settings.

The concept of quality nursing care developed in this study has implications for quality improvement. The concept delineates actual practice (i.e., process) indicators of quality nursing care and may make evaluation of nursing care process feasible. Further examination of domains and their attributes that contribute to quality care for this group of patients will provide valuable information about how to ask patients to evaluate nursing care and what nurses can do to improve their care. The finding of an interaction between level of vulnerability and patient perception of quality of care for hospitalized patients with advanced illness poses an intriguing challenge for measurement. As a next step, an instrument to assess the quality of nursing care for patients with advanced illness is being developed to build on and validate the concept as developed in this study.

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Table 1

Domains of Quality Nursing Care and Their Attributes

Domains	Definitions	Attributes Nurses who give quality care:
Competence	Ability to provide care to meet patients' various needs. Nurses have knowledge and skills to assess patient's needs, determine the best intervention, and carry out the intervention to meet the patient's needs.	Take care of patients' needs. Attend to individual needs. Respond to patients in timely manner. Are knowledgeable. Are technically skillful. Explain and answer questions. Communicate with healthcare team.
Caring	Concerns and compassion for patients as fellow humans. Nurses respect and treat patients as persons, and go beyond duties to reach out and do good for patients.	Treat patients as persons. Care about patients. Get to know patients as persons beyond illness. Have personal relationships with patients. Go beyond duties/routines.
Professionalism	Conduct and attitudes reflecting the societal values of professional. Nurses committed to act in accountable, autonomous, and self-disciplined manner.	Are responsible/accountable. Are willing to work. Do not bring personal issues to work. Are committed to improve care. Are willing to keep learning. Are fair and honest.
Demeanor	Behaviors and presentation of selves to patients. Nurses convey their competence, caring, and professionalism in their behavior.	Are kind/patient/calm/gentle. Are friendly/easy to talk. Are respectful/courteous. Are pleasant/work with smile. Are confident.

Table 2

Comparison of Themes and Domains Identified from 22 Qualitative Studies on Patients Perspectives of Quality Nursing Care

Qualitative study	Sample/Question	Competence	Caring	Professionalism	Demeanor	Others
1. Taylor et al. (1991) Content analysis (USA)	70 patients (and 70 significant others). 2 weeks after discharge from a hospital. Telephone interview. "Describe what you think quality nursing care is."	• Total patient care • Patient education • Effective communication • Knowledgeable • Technically competent	• Patient-centered care • Caring	• Professional character • Best possible care	• Kind, nice, friendly • Flexible • Efficient • Helpful • Gentle • Courteous • Conscientious • Confident	• Family involvement • Effective organization and management • Patient environment
2. Häggman- Laitila & Åstedt-Kurki (1994) Content analysis (Finland)	60 in-hospital patients and 40 outpatients. Interview. "What is quality of a good nurse and a poor nurse?"	• Careful, observant, accurate • Inquire patient's needs • Offer alternatives • Sensitive • Provide information • Cooperative with other team members • Fulfilling patients' needs	• Treat patient as an individual • Interest in patient's feelings/ experiences • Introduce self to patient • Regard patient as an equal co-partner • Discuss with patients other matters than their illness	• Treat patient equally, justly • Honest • Protect patient's intimacy and confidentiality • Assume responsibility	• Kind, gentle • Genuine • Good humor • Conscientious	
3. Wilde et al. (1993) Grounded Theory (Sweden)	20 hospitalized patients with infectious disease. Interviews. "What are important issues in the care you received? Positive or negative care?"	• Medical-technical competence (have knowledge and proficient)	• Identity-oriented approach (show interest and commitment to the patient as a person, symmetrical relationship, mutual understanding)	• Identity-oriented approach (inform patient who is responsible for his care)	• Identity-oriented approach (warm, nice, honest, sincere, cheerful, pleasant, kind, decent)	• Physical and administrative environment (equipment available, clean, comfortable, safe environment, access to TV phone.)
4. Burfitt et al. (1993) Phenomenologi cal study (USA)	13 patients within 48 hours of transfer from ICU. Interviews. "Describe nurses caring in ICU."	• Attentiveness • Highly skilled practice • Lifesaving behaviors	• The basics and beyond • Nurturing • Mutuality (feel with patient) • Compassionate			

Qualitative study	Sample/Question	Competence	Caring	Professionalism	Demeanor	Others
5. Fosbinder (1994) Qualitative analysis (USA)	40 patients in ortho/chest/ cardiac wards in a teaching hospital. Observation and interviews. “What happened and how you felt about care?”	• Translating (informing, explaining, instructing, teaching) • Establishing trust (being in charge, anticipating needs, being prompt, following through)	• Getting to know you (personal sharing, clicking) • Going the extra mile (being a friend, doing the extra)	• Establishing trust (enjoying the job)	• Getting to know you (humor, friendly)	
6. Beech & Norman (1995) Critical Incident Technique (UK)	24 psychiatric patients in2 psychiatric wards. Interviews. “High and low quality psychiatric nursing care incident.”	• Handling violence and disturbance (deftness)	• Communicating caring (being available, listening, actions explained) • Respect • Nurses attribute (being caring, showing an interest in people)	• Nurses attribute (enthusiasm for the job)	• Ward atmosphere • Attributes (friendliness, being cheerful, kindness, having patience, tolerance)	• Nursing staffing
7. Milburn et al. (1995) Grounded theory (UK)	30 patients in med/oncology wards. 25 follow-up 6 weeks after discharge (5 died before 2nd interview). Interviews. “What care would you like from a nurse?”	• Knowledge (physical care, theoretical knowledge) • Information giving	• Listening/talking time • Being there for the patient • Psychological care • Respect for the individual (personal touch)		• Atmosphere: social environment (kind, caring, friendly, calm, smiling, cheerful nurse)	• Continuity of care from same nurses
8. Thomas et al. (1995) Content analysis (UK)	100 medical/surgical patients during and/or after discharge. Interviews and/or focus group. “What was an example of good nursing?”	• Attentiveness • Availability • Information giving • Nurses’ knowledge (know about patient as individual and their treatment)	• Individual treatment	• Professionalism (conduct and composure, not show negative emotions, never complain, equal treatment)	• Nurses’ manner • Openness/informality	• Ward organization (continuity of care, same nurse, good communication between shifts) • Ward environment (food, noise, temperature, lighting)
9. Lynn & Sidani (1995) Grounded theory (USA)	25 med/surg/ob/ped patients in medical centers. Interviews How do you describe or define good nursing care?”	• Being instructive/facilitative • Vigilant • Technically competent	• Being with patients and family • Communicating that the patient is the nurses’ first concerns • Getting to know the patient • Respect as a person		• Being patient	• Environment
10. Irurita (1996) Grounded theory (Australia)	23 patients following their discharge from >5 days hospital stay. Interviews.	• Firm-hand care (technical competence, providing adequate relevant information in timely	• Soft-hand care (go extra, being there, use of touch, empathy and compassion)	• Firm-hand care (equalize the power imbalance) • Soft-hand care (Nothing is too much trouble for	• Soft-hand care (kind)	

Qualitative study	Sample/Question	Competence	Caring	Professionalism	Demeanor	Others
	To explore quality care from the hospitalized patient's perspective.	manner, facilitate patient independence)		them, be a patient advocate)		
11. Walker et al. (1998) Grounded theory (UK)	18 patients 4–6 weeks after inpatient care or day surgery. Interviews. To understand patients' experiences of hospitalization (not limited to nursing care).	• Feeling adequately informed	• Feeling valued as an individual (staff care about patients, know how they feel, and have time for them) • Interpersonal skill • Reciprocal attitude of caring			• Feeling at home (physically, environmentally)
12. Middleton & Lumby (1999) Content analysis (Australia)	16 orthopedic male patients 4.5month (average) after surgery. Focus group. "What was/not done for you by the nursing staff that made differences to your outcome?"	• Patient-Controlled Analgesia • Heel care • Explanation about treatment • Inform patients about the treatment				• Comfortable environment (cold shower, control noise, access to drinks/phone)
13. Redmond & Sorrell (1999) Phenomenological research (USA)	20 patients 1–2 weeks after discharged from acute rural hospitals. Interviews. "Describe an experience that indicates quality (poor) care."	• Knowledgeable watchfulness (monitoring the physical status, sensing when they need support and comfort, explanation)	• Knowledgeable watchfulness (caring) • Thoughtful presence	• Knowledgeable watchfulness (professional judgment)		
14. Oermann (1999) Qualitative analysis (USA)	239 consumers recruited from clinic waiting rooms and in neighborhoods. Interviews. "Describe quality nursing care and experiences that you felt represented quality care."	• Competent and skilled • Communicate effectively with patients • Teach patients about their condition, treatment, medication, and selfcare	• Concerned about patients • Demonstrating caring behaviors • Treat patients with respect			
15. Redfern & Norman (1999) Critical Incident Technique (UK)	96 patients from elderly/ medical/surgical wards. Interviews. Perception of high and low quality nursing care.	• Monitoring/assessment/ documentation/information giving • Skillful treatment • Efficiency and thoroughness • Anticipation and reaction in care • Comprehensive clinical knowledge • Health education • Effective crisis management • Effective communication to ensure continuity of care	• Have time for patient • Show concern, take time to talk • Take a personal interest in patients as individuals • Engage with them as partners	• Give impression of nothing was too much trouble • Maintain dignity, ensure confidentiality, respect patient's wish, no value judgments, keep promise • Teaching nurses, leadership, critique • Work ethics/philosophy of care • Take pride in their work	• Friendly, approachable, not impose unnecessary restrictions • Respect, courtesy, affectionate, humor • Even-tempered, calm	• Equipment. adequate resources, support service, and time to do a good job

Qualitative study	Sample/Question	Competence	Caring	Professionalism	Demeanor	Others
16. Radwin (2000) Grounded theory (USA)	22 oncology patients (include newly diagnosed, chronic, and terminal stage). Interviews. "Describe quality nursing care, and episode of non/ excellent nursing care."	• Professional knowledge and technical competence • Attentiveness (address patient needs promptly) • Coordination (coordination of care and teamwork)	• Partnership • Individualization • Rapport (patients know about the nurse) • Caring (express concern, nurturing, remember the patient)			• Continuity
17. Attree (2001) Grounded theory (UK)	34 acute medical patients and 7 relatives in general hospitals. Interviews. "Describe examples of care which you thought was good quality and which was not."	• Relate to need • Need anticipated • Open communication and information passage • Time availability and accessibility	• Patient focused • Individualized • Inclusive care • Sociable relationship • Bond/rapport • Patients as people • Concern • Compassion and sensitivity shown	• Help offered willingly	• Kind • Cheerful • Happy • Smiling • Showed good humor • Unhurried manner	
18. Larrabee & Bolden (2001) Qualitative analysis (USA)	199 hospitalized medical/ surgical patients. Interviews. "What is good nursing care?"	• Provide for my needs • Being competent • Provide prompt care	• Care about me		• Treat me pleasantly	
19. Stichler & Weiss (2001) Content analysis (USA)	39 women in a hospital-based women's health care clinic. Interviews "What is quality care? (not specific for nursing care.)"	• Competent staff (technical skill, accuracy, effective treatments) • Timeliness (timely response, efficient, be ready, keep things moving on schedule)	• Personalized caring (Take a personal interest in me, treat me right, helpful)		• Display strong professional demeanor • Friendly	• Environment/ facility (clean and comfortable, privacy, familiar and home-like environment)
20. Thorsteinsson (2002) Phenomenological study (Iceland)	11 patients with chronic disease with hospitalization experiences. Interviews. "What is quality of nursing care?"	• Clinical competence • Sensitivity to patients' needs • Patient teaching	• Genuine concern	• Trust and honesty	• Kind • Good attitude and manner (joyful, warm, tender, smiling, positive, polite, understanding) • Use humor	• Ancillary factors • (hotel factors)
21. Redman & Lynn (2005) Qualitative analysis (USA)	20 medical/surgical patients in academic medical center. Interviews.	• Provider competence (careful, accurate, timely treatments, thorough, knowledgeable, well informed).	• Respect and caring • Individualization of care	• Provider behavior (act professional, leave	• Provider behavior (humor)	• Hotel services

Qualitative study	Sample/Question	Competence	Caring	Professionalism	Demeanor	Others
	"What are your expectations for care?"	• Education/communication • Anticipation of needs		personal problems at home)		
22. Izumi et al. (2006) Phenomenological study (Japan)	26 oncology patients who have experiences of hospitalization. Interviews. "What are characteristics and attributes of good nurses?"	• Professional Competence (technically skillful, capture patients needs, ability to make judgment, communication, having knowledge.)	• Presenting oneself as a person • Interested in a patient as a person • Caring for a patient as a precious person	• Professional disposition (Have pride and passion for doing a good job, responsible, keep promise, take responsibility, strive to improve skills and knowledge)	• Good persons (cheerful, kind, smiling, warm, gentle, compassionate, sensitive, hopeful, have sense of humor, courteous)	

Note: Findings in this table are not always presented in comparable/symmetrical terms. To avoid misinterpretation of the findings, the terms used in the articles have been used in the table rather than modifying them for grammatical consistency.