UMass Chan Medical School
Tan Chingfen Graduate School of Nursing

“I felt isolated”: Patients’ Hospitalization Experiences During the COVID-19 Pandemic

A Dissertation Presented

By

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Abstract

**Purpose:** The purpose of this Qualitative Descriptive study was to describe the experience of hospitalized adults during the pandemic who did not have COVID-19.

**Specific Aims:** The specific aims of the study were to:
1. Describe the hospital experience, including but not limited to, interactions with hospital staff, visitation, isolation, physical and emotional stressors, and the environment.
2. Identify perceived comfort needs during hospitalization and perceptions of the nurse’s role in providing comforting interventions.
3. Examine the ability to achieve physical, psychospiritual, sociocultural, and environmental comfort during hospitalization despite the required infection control measures.

**Framework:** This study was guided by Kolcaba’s Theory of Comfort (1994).

**Design:** This was a qualitative descriptive study. Semi-structured interviews were conducted. Interview questions focused on the overall hospital experience, the nurse’s role in their experience, comfort needs, and the experience of having comfort needs met during the hospitalization.

**Results:** Twenty participants took part in this study. Conventional content analysis revealed five main themes. The themes are: I don’t expect the hospital to be comfortable, I was always tense, Wanting human connection, Communication is important, and Nurses are busy.

**Conclusion:** These findings identified a need for targeting education, research, and policy development to improve patient comfort (physical, psycho-spiritual, sociocultural, and environmental). This is important as we look toward improving the overall patient experience during hospitalization.

**Keywords:** Patient experience, Patient Perception, Nursing Care, COVID-19, Hospitalization, Comfort needs
Dissertation Proposal

Introduction

Hospitalization is a stressful experience for patients and contributes to psychological distress including depression and anxiety (Chang, 2019; Gammon, 1998; Shuldham et al., 1995). Being hospitalized during the COVID-19 pandemic involved additional stressors because of concern and uncertainty about the severity of the virus, worry about transmission, and the lack of evidenced based treatment especially prior to the development and availability of vaccines to prevent COVID-19. Understanding the experience of patients hospitalized during the COVID-19 pandemic who did not have COVID-19 yet were subject to infection control policies limiting face-to-face interactions and visitation by family and friends may help healthcare providers understand the impact these experiences had on psychological and physical health.

In a large academic medical center in Massachusetts, there was only 1 case of hospital acquired COVID-19 at the height of the pandemic highlighting the benefits of infection control measures including universal masking, restriction of visitors, and use of personal protective equipment (PPE) as recommended by the US Centers for Disease Control and Prevention (Rhee et al., 2020). To decrease transmission of COVID-19 within the hospital, new hospital infection control measures were put into place in early 2020, at the start of the pandemic, to limit interaction and increase space and physical barriers between individuals. Health care facilities around the world implemented infection control practices that required staff to wear PPE at all times (Calderwood et al., 2020). In many hospitals, patients were also required to wear masks whenever anyone entered their room (Calderwood et al., 2020). These changes meant that interactions and communication between hospital staff, patients, and visitors were limited and
occurred with people wearing a face mask and a face shield or goggles, altering the usual frequency and kinds of exchanges between individuals.

Hospital infection control measures related to the COVID-19 pandemic contributed to shortened and less frequent in-room encounters with hospital staff and visitors (Auerbach et al., 2020; Calderwood et al., 2020), leaving patients isolated and alone for much of their hospital stay. The amount of time nurses spend with patients is directly tied to better patient health outcomes (Westbrook et al., 2011). A therapeutic nursing relationship is important to achieving positive health outcomes (Westbrook et al., 2011) and the extent to which the nurse-patient relationship was affected by the new infection control measures is unknown. A decrease in physical interaction and use of PPE as required by new hospital policies may be necessary to decrease transmission of communicable diseases (Auerbach et al., 2020) but it is important to understand if and how these changes affect the comfort of patients and their overall hospitalization experience.

The purpose of this Qualitative Descriptive (QD) study is to describe the experience of adults hospitalized without COVID-19 during the pandemic, focusing on understanding their perception of having their comfort needs met despite the infection control measures in place during this time. Kolcaba’s Theory of Comfort (Kolcaba, 1994) will guide the development of the study and the interpretation of results. I will interview adults who were hospitalized during the pandemic, and were negative for COVID-19 throughout their entire stay, to achieve the following specific aims:

4. Describe the hospital experience, including but not limited to, interactions with hospital staff, visitation, isolation, physical and emotional stressors, and the environment.
5. Identify perceived comfort needs during hospitalization and perceptions of the nurse’s role in providing comforting interventions.

6. Examine the ability to achieve physical, psychospiritual, sociocultural, and environmental comfort during hospitalization despite the required infection control measures.

The likelihood of future pandemics and other communicable epidemics is high (WHO, 2020). Understanding the experience, psychological impact, and comfort needs of patients who are hospitalized during a pandemic will inform hospital policies and lead to development and testing of potential interventions to meet the comfort needs of patients, improve recovery, and improve the patient experience. It is essential that we learn from these experiences to prepare for future pandemic situations to be positioned to provide patient-centered, holistic nursing care despite implementation of health protective policies.

The COVID-19 Pandemic: Changes in the Acute Care Setting

On January 21, 2020, the first case of COVID-19 was reported in the United States (AJMC, 2021). COVID-19, also referred to as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), results from infection with a coronavirus that causes respiratory illnesses which can become severe and result in death (Wiersinga & Prescott, 2020). Since the start of the COVID-19 pandemic, there have been immense changes to health care. Hospitals adjusted to the demands of the pandemic as it evolved. In April of 2020, non-COVID-19 hospitalization rates declined by almost 43% as concern arose about risk of exposure and associated hesitancy from patients and providers but these numbers were steadily returning to pre-pandemic numbers by July of 2020 (Birkmeyer et al., 2020).

Early in the pandemic, hospitals enacted strict infection control measures that changed the hospital experience for patients and their families. Many hospitals enforced policies that
prohibited patients from having visitors, with exceptions made in 69% of hospitals for special circumstances such as birthing partners, parents of children, and end-of-life family members (Calderwood et al., 2020; Griffin, 2020; Gupta & Federman, 2020, Siddiqi, 2020). Health outcomes often improve when patients can visit with family members, especially when the visitation policies are flexible and in favor of the patient and family members (Goldfarb et al., 2017, Siddiqi, 2020). However, the strict visitation policies put into place in many hospitals during the COVID-19 pandemic were deemed necessary to decrease virus transmission (Siddiqi, 2020).

Universal mask-wearing was deemed a necessary infection control measure by healthcare facilities around the world. Limiting spread of infection amongst seemingly uninfected individuals is essential and the health care facility is an especially vulnerable location for infection (Klompas et al., 2020). Sixty-two percent of hospitals required inpatients to also don masks when staff members were in the room (Calderwood et al., 2020). Mask wearing decreases non-verbal communication by limiting the ability to read facial expressions and may make communication difficult for patients (Frith, 2009). Facial expressions are an important contribution to human communication and critical for expressing emotion (Frith, 2009). Mask wearing also hinders the quality of sound produced by diminishing the sound and changing the tones (Goldin et al., 2020). The impact of hospital staff wearing masks consistently on the patient experience is not known.

**Acute Care Hospitalization: The Patient Experience**

The Beryl Institute defines patient experience as “the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care” (The Beryl Institute, 2021). Patient experience is the patient’s perception of their journey (Wooldridge
Patient experience, as a measure of quality, has gained recognition as an important consideration in healthcare since the implementation of the Affordable Care Act which places high importance in the provision of care that improves patient experience by creating financial incentives for health care facilities to perform well (Berkowitz, 2016). The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a standardized tool used to measure patient perceptions of care received during an inpatient hospital stay (Centers for Medicare and Medicaid Services, 2020). In 2010, the Patient Protection and Affordable Care Act began to require HCAHPS scores when calculating hospital reimbursements using a new Hospital Value-Based Purchasing program (Centers for Medicare and Medicaid Services, 2020). Aside from reimbursement based on survey scores, research suggests that positive patient experience leads to greater profitability for the healthcare facility (Betts et al., 2016).

Although the HCAHPS is widely accepted and widely used among hospitals, it does not capture the full extent of the patient experience. The terms “patient experience” and “patient satisfaction” are often interchanged but it is important to recognize the difference. Patient satisfaction refers to the patient’s perception of whether care met the patient’s expectations (Wooldridge & Camp, 2019). Measuring patient satisfaction will not increase understanding of the experience of emotions, nor will it identify the details within the experience that improved, or hindered, a positive patient experience. The goal of this study is to understand the patient experience which is not adequately captured by the HCAHPS alone.

**Psychosocial Stressors During Hospitalization**

After several years of little research on the stressors associated with hospitalization, Chang et al. (2019) and Baldwin and Spears (2019) confirm data initially published almost 40 years ago (Shuldham et al., 1995; Zigmond & Snaith, 1982), indicating that hospitalization is
stressful on patients. The experience of illness may elicit a stress response that is ineffective and lead to damaging psychological effects for patients (Chang, 2019). Increased threat perceptions during a traumatic experience negatively impacts a patient’s ability to respond to medical events and can lead to long term negative health effects after hospitalization. This increased perception of threat that occurs due to stressors can lead to worsened acute stress and symptoms of post-traumatic stress disorder following hospitalization (Chang, 2019). The severity of, and response to stress, can be amplified by pre-existing mental health conditions such as anxiety and depression (Connell et al., 1994; Muris et al., 2000). While the experience of hospitalization can be stressful for all patients, coping abilities may be worse for patients who suffer from mental health conditions prior to hospitalization (Chang, 2019).

Patients can experience psychologic stress related to the hospital physical environment (Chang, 2019). Historically, there has been little consideration of patient needs in the planning of hospitals’ physical layouts (Gulrajani, 1995). Patients who are hospitalized often have little privacy and no way to diminish the negative stimuli of the hospital environment, such as unpleasant lighting and noise. Patients are often in small rooms that are shared with another patient, limiting the space for visitors, and making ambulation within the room difficult. The hospital environment often makes it difficult to achieve quality sleep which can lead to confusion, depression, anxiety, and decreased cognitive abilities (Dobing et al., 2016). The psychological distress during hospitalization, caused by experiences of fear, anxiety, illness, and discomfort in the hospital environment, can lead to worsened patient outcomes such as chronic pain, increased mortality rates, and decreased recovery rates post-hospitalization (Lagraauw & Kuiper, 2015).
Psychological Impact of Source Isolation

Source isolation is the practice within the hospital of preventing the spread of an infection by isolating the source of the spread (Abad et al., 2010). Source isolation is implemented for communicable diseases, including historic disease outbreaks such as SARS and EBOLA virus (Maunder et al., 2003). Patients who are on isolation may be confined to a private room, have limited interaction with staff and visitors, and interactions that the patient does have, are done with the barrier of PPE. A small qualitative study compared the experiences of 19 patients with Severe Acute Respiratory Syndrome (SARS) to patients without SARS during the outbreak in 2003 (Maunder et al., 2003). Patients with SARS expressed sadness due to missing their loved ones and fear of the lethality of the disease and transmitting the disease to others. Patients without SARS who were hospitalized and denied visits with family members experienced insomnia, anxiety, and often had negative interactions and relationships with staff. Patients without SARS complained of limited access to items that would normally provide them comfort (Maunder et al., 2003).

During the 2002-2004 SARS outbreak, Chua et al. (2004) administered a questionnaire to patients with SARS and healthy control subjects and reported that both groups experienced increased levels of stress, with SARS patients scoring higher levels of stress than healthy control subjects. Ninety percent of the participants stated that the SARS outbreak affected them psychologically. Negative effects included worry about health and fatigue, fear of social contact, poor sleep, loneliness, increased weeping, boredom, and depression (Chua et al., 2004). Participants also stated positive psychological effects of the SARS outbreak including increased awareness of hygiene and physical state, as well as feeling “united” (Chua et al., 2004). This study was the first to identify positive effects of an outbreak event. Similarly, Catalano et al.
(2003) found that anxiety and depression scores increased over time in adult patients who were hospitalized on isolation. In contrast, it was found that anxiety and depression scores decreased over time for patients who were not on isolation precautions (Catalano et al., 2003).

Since the SARS outbreak, few studies have examined the impact of source isolation on patient experience but as Abad et al. reported in 2010, source isolation has a negative impact on patients’ mental health and can negatively affect patient behavior. Abad and colleagues’ (2010) results confirmed those from earlier research in which patients on source isolation scored higher for depression and anxiety than those who were not on isolation precautions (Catalano et al., 2003; Gammon, 1998; Tarzi et al., 2001). Adult patients who are isolated also have higher anger-hostility scores (Kennedy & Hamilton, 1997) and report feelings of fear and loneliness (Maunder et al. 2003; Newton et al., 2001). Isolation also changes the way some patients perceive care from their nurses. Findings from a study of 528 patients found that patients on contact precautions were more likely to report poor care coordination and a lack of respect for their needs and preferences (Mehrotra et al., 2013).

Summary

The COVID-19 pandemic brought new challenges to health care and to patients. It is imperative that we understand the experience of patients hospitalized during the pandemic and this study will focus on those who were hospitalized without a COVID-19 infection. Isolation and hospitalization are stressful experiences in non-pandemic times. It is important to understand if and how the experience of hospitalization for all patients is impacted by infection control measures instituted for the safety of the patients and the hospital staff.
**Theoretical Framework**

The Comfort Theory is a middle-range theory explaining the relationship between patient needs, nursing interventions, comfort, and the outcomes that result when comfort is achieved (Kolcaba, 1994). Kolcaba describes comfort as a holistic outcome, with comfort encompassing the whole body, mind, and spirit of human beings. Patients who achieve and maintain comfort become stronger and more able to heal than patients who stay in a state of discomfort (Kolcaba, 1991). The Theory of Comfort provides nurses with a framework (Figure 1) to promote comfort (relief, ease, and transcendence) by identifying and addressing the noxious stimuli in physical, psychospiritual, sociocultural and environmental contexts (Kolcaba, 1994).

Fig. 1. Reprinted with permission from Katharine Kolcaba, The Comfort Line, 2010

Kolcaba’s framework shows the relationship between patient needs, interventions that improve comfort, influence of intervening variables, the achievement of comfort, and the development of health-seeking behaviors. Intervening variables are the things in a patient’s life that the nurse cannot change such as the patient’s financial status and diagnosis (Kolcaba, 2001). Patients hospitalized during the COVID-19 pandemic may have unique intervening variables that...
influence the ability to achieve comfort including mask wearing, communication challenges, and decreased access to family and visitors.

**Comfort: Forms and Contexts**

Kolcaba (1994) describes three forms of comfort and four contexts in which comfort is achieved. The three forms of comfort are relief, ease, and transcendence. Kolcaba (1994) defines relief as the experience of having basic needs met. Ease is the state of calm and contentment. Transcendence is the state in which the individual can move beyond the challenges they are faced with. Enhanced comfort in these three forms leads to health seeking behaviors which facilitate healing or a peaceful death.

The four contexts in which comfort is experienced are physical, psychospiritual, sociocultural, and environmental (Kolcaba, 1991). Patients experience comfort in the physical context when bodily sensations and disruptions to homeostasis, such as pain, fever, and itching are addressed. Comfort in the psychospiritual context is experienced when patients have feelings of self-worth and self-confidence, as well as confidence in spiritual and/or religious beliefs. Comfort in the sociocultural context is experienced when there is comfort in the person’s personal relationships and the state of personal affairs such as financial stability and the location in which they live. Family involvement is an important aspect of this area of comfort. Comfort within the environmental context is related to the patients’ surroundings. The environment includes the aesthetics and conditions of the environment. This includes things such as the comfort of the furniture, temperature of the room, and absence of excess noise.

The conceptual framework for comfort theory will be used as a guide for this study to assess the impact of new infection control measures (perceived as a potential intervening variable within the Comfort Theory framework) on perception and achievement of patient
comfort. All classes of comfort needs must be carefully considered for patients to best transcend the stress of illness and hospitalization. In this study, I will be exploring the comfort needs of patients and their perception of the presence or deficit of comforting interventions by nurses. I will also be exploring patients’ abilities to achieve relief, ease, and transcendence during their hospital stay.

Methods

Design

This study will use a qualitative descriptive (QD) approach to describe the experience of hospitalization in the acute care setting during the COVID-19 pandemic for adults without a COVID-19 infection. QD is a method of naturalistic inquiry in which the phenomenon is studied in its natural state (Sandelowski, 2000; Willis, 2016). QD gathers data from multiple sources to describe complex experiences in everyday language that requires little interpretation (Sandelowski, 2000; Sullivan-Bolyai et al., 2005). The rich description provided by QD allows researchers to gather information about poorly understood experiences that can be easily understood by both researchers and non-researchers (Sullivan-Bolyai et al., 2005). QD will generate a comprehensive descriptive summary of the experience of being hospitalized in an acute care hospital, without COVID-19, during the COVID-19 pandemic. Data will be gathered through semi-structured interviews and observations.

Sample

Purposive sampling will be used to recruit adult participants who were hospitalized during the pandemic and negative for COVID-19 throughout their entire stay. Inclusion criteria include English-speaking adults over the age of 18, who were hospitalized on a medical or surgical floor for a minimum of 2 consecutive nights after April 1, 2020 and were negative for
COVID-19 throughout their entire hospital stay. If recruitment is a challenge, the end date of December 31, 2020 will be removed to include any participant who was hospitalized after April 1, 2020. Participants must have internet access and be willing to participate in a video interview via Zoom. Exclusion criteria include patients on isolation precautions during their hospitalization for a reason other than COVID-19 and patients hospitalized for greater than 10 days.

**Setting**

Zoom interviews will be private, taking place in a confidential space that allows privacy and freedom to speak openly without distraction or interruption. Participants will choose their location of preference with access to the internet. Consent will be obtained for digital recording of the audio during interviews.

**Recruitment**

Recruitment and data collection will continue until informational redundancy is achieved and no new information is gained, with an initial target of 20 participants. Purposeful sampling with demographic variation in the sample will be sought to achieve maximum variation. Purposive sampling allows the researcher to select participants based on their ability to provide meaningful and thorough accounts of the experience (Sullivan-Bolyai & Bova, 2021). Recruitment will occur via an advertisement on social media platforms including Facebook, Instagram, and Twitter which will enable me to reach a geographically diverse population (Appendix A). The advertisement will have a link that will take potential participants to a web page (Appendix B) where they will find the inclusion/exclusion criteria, a Fact Sheet describing details of the study, and contact information should they wish to proceed with scheduling a Zoom interview. I will contact those who are interested, confirm eligibility, respond to any questions, and as appropriate, schedule a date and time to complete the interview.
Data Collection

Approval from the University of Massachusetts Medical School Institutional Review Board (IRB) will be obtained prior to data collection. A Fact Sheet (Appendix B) will be shared with each potential participant, and I will review and answer any questions they may have. Verbal consent will be obtained from each participant prior to the interview.

A semi-structured interview guide with open-ended questions and prompts (Appendix C) will guide the interview process. Probes will be designed for clarification purposes and for eliciting a deeper understanding. I will take field notes of significant observations during the interview. The interviews are expected to last approximately 60 minutes. After the interview, participants will be asked to provide demographic information including age, gender, ethnicity, location of hospital admission, distance of residence to the hospital, reason for hospital admission, length of hospital stay, and number of previous hospital admissions which I will document and store on a protected research drive. Interviews with participants will continue until informational redundancy has been reached and little new information is obtained. The de-identified, recorded data will be transcribed using Microsoft Word’s transcribe feature and will be checked for accuracy.

Data Management

Participant confidentiality will be maintained by assigning a unique number to data collected from each participant. Digital audio recordings, demographic data, field notes, and the transcriptions will be labeled with the ID number. Recordings will be destroyed after accuracy of the transcriptions has been verified. A reflexive journal and field notes will be collected to maintain an audit trail for confirmability (Lincoln & Guba, 1985) and all study materials will be stored on a password protected UMMS research drive. Dedoose© software will be used to
analyze transcriptions. There will be no physical copies of any documents. Access to study data will be limited to myself and dissertation committee members. All data will be deleted 3 years after completion of the study.

**Data Analysis**

The interview transcriptions will be analyzed using the analytic strategy of conventional content analysis described by Hsieh and Shannon (2005). Conventional content analysis strives to find meaning in text by allowing categories of information to be derived directly from the words of the text. To find these new insights from the data, an iterative process will occur. Analysis will begin with reading the transcriptions thoroughly to gain a general understanding and summary of the participants’ experiences. Then the transcripts will be read again, coding the data one section at a time using the exact words of the participants. I will make notes about initial thoughts while first reading the transcript and develop codes for the concepts and ideas that are found. Similar codes will be sorted into categories and subcategories. Definitions will be applied to the codes, categories, and subcategories, based on the information retrieved from the data. This allows an analysis of data that is derived directly from the data and is influenced minimally by the researcher’s interpretation or preconceived ideas (Hsieh & Shannon, 2005). Descriptive statistics will be run on demographic data using SPSS.

**Trustworthiness**

To establish trustworthiness using Lincoln and Guba’s naturalistic paradigm, the criteria of credibility, transferability, dependability, and confirmability, will be demonstrated. To achieve credibility, I will debrief regularly with my committee members, collect observations during interviews, and confirm my understanding of content shared during each interview with each participant.
To establish transferability, the researcher must ensure that any findings and conclusions developed from the data, can be found by external researchers who analyze the same data. I will consult with my committee members on the data analysis/coding process for each transcript including code definitions, and the organization of categories and subcategories. I will provide extensive contextual information to describe the study setting and the participants.

An audit trail will be kept to establish dependability. Rich and thick data that is detailed, specific, high quality, and of high quantities, will help establish dependability by allowing others to examine the data and ensure that the findings are consistent. Thick data will be achieved by obtaining an adequate sample size and using strong open-ended questions which provide useful quotes and contributes to the richness of the data (Morse, 2015). Representative quotes will be included to demonstrate that the findings match the data based on the participants’ own words.

Reflexivity involves acknowledging our own thoughts, emotions and biases in order to prevent them from altering the results of our qualitative research (Mitchell, 2018). I will debrief with the dissertation committee and keep a reflexive journal to help me acknowledge emotions and biases to prevent them from influencing the data. Given my previous hospitalization experiences, it will be especially important to maintain reflexivity. Reflecting on biases and pre-existing emotions and hypotheses is crucial to assuring that the results are not representative of the researcher’s thoughts, but those of the participants.

Protection of Human Subjects

Approval of the study plan will be obtained from the UMMS IRB. Participant risk will be minimal but should any participant experience difficult emotions in relaying stories of their hospitalization, and wish to speak to someone further, they will be advised to contact their primary care provider or the Substance Abuse and Mental Health Service Administration
(SAMHSA) national Helpline at 1-800-662-HELP. The participant can opt out of participation, or may choose to pause or stop the interview at any time. Participants will be assured that information will be confidential and de-identified. All participants will be offered a $25 Bank of America gift card.

**Limitations**

There are limitations to this study. As participants were selected from medical or surgical units in an acute care hospital, the outcomes of this study may not be reflective of experiences in other areas of the hospital such as intensive care units, pediatric units and maternity units. Data will only be obtained from English speaking adults which may not represent the experiences of non-English speaking adults. Due to the nature of being hospitalized, factors such as lack of sleep, excessive pain, and medications, cognition may have been altered during hospitalization, influencing the accurate recall of information.

Another potential limitation is recall bias. Due to the lapse in time, it is possible that some information may be forgotten at the time of the interview, but loss of recall is less likely with salient events. The interview guide (Appendix C) will promote recall of these important events that occurred during hospitalization.

**Possible methodological challenges and alternative approaches**

Recruitment may be challenging. If the current plan is inadequate, recruitment through a local hospital, snowball sampling, and networking with the Beryl Institute will be considered. Reflexivity may also be a challenge due to my personal experience with hospitalization. Maintaining a reflexive journal and debriefing with committee members will help limit bias.
Conclusion

Helping patients achieve comfort is an essential aspect of nursing care but the COVID-19 pandemic has created new challenges for nurses and patients. Understanding the experience of patients who were hospitalized without COVID-19 during the pandemic is crucial for the preparation of meeting patient’s needs in future pandemics, or pandemic-like situations. Understanding the hospital experience, specifically the identification and meeting of comfort needs of patients who were hospitalized during a pandemic, will provide the data to develop and test interventions needed to optimize the hospital experience and enhance overall recovery. Using comfort theory as a guide, this study will describe the experience of adults hospitalized without COVID-19 during the pandemic, and patients’ perceptions of the nurse’s role in helping them achieve relief, ease, and transcendence. Findings from this study can inform nursing practice and lead to policy change that better addresses the comfort needs of patients.
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Summary of Changes from Proposal

This study utilized a qualitative descriptive design to describe the experience of hospitalized adults during the pandemic who did not have COVID-19, specifically related to the experience of having comfort needs met. The following change was made from the original proposal:

- Due to recruitment challenges, the inclusion criteria of being hospitalized between April 1, 2020 and December 31, 2020, was changed to include those who were hospitalized any time after April 1, 2020.
“I felt isolated”: 
Patients’ Hospitalization Experiences During the COVID-19 Pandemic

Julia Patrick MSN, RN

Hospitalization is a stressful experience for patients and contributes to psychological distress including depression and anxiety

- Being hospitalized during the COVID-19 pandemic involved additional stressors
- New hospital infection control measures were put into place to limit interaction and increase space and physical barriers between individuals.
- A therapeutic nursing relationship is important for achieving positive health outcomes and the extent to which the nurse-patient relationship was affected by the infection control measures implemented during the COVID-19 pandemic is unknown
Patient experience is defined as “the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care” (The Beryl Institute, 2021).

- Patient experience is the patient’s perception of their journey (Wooldridge & Camp, 2019).
- The psychological distress during hospitalization, caused by experiences of fear, anxiety, illness, and discomfort in the hospital environment, can lead to worsened patient outcomes such as chronic pain, increased mortality rates, and decreased recovery rates post-hospitalization (Lagrauw & Kuiper, 2015).
- Understanding the experience, psychological impact, and comfort needs of patients who are hospitalized during a pandemic will inform hospital policies and lead to development and testing of potential interventions to meet the comfort needs of patients, improve recovery, and improve the patient experience.

### The Comfort Theory

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<thead>
<tr>
<th></th>
<th>Relief</th>
<th>Ease</th>
<th>Transcendence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Pain, nausea</td>
<td></td>
<td></td>
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<tr>
<td>Psychospiritual</td>
<td>Fear, stress, family concerns,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>loss of control</td>
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<tr>
<td>Environmental</td>
<td>Noise, light, color</td>
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<tr>
<td>Sociocultural</td>
<td>Social support (staff, family),</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>language, information</td>
<td></td>
<td></td>
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</tbody>
</table>

Recreated with permission from Katharine Kolcaba, The Comfort Line, 2021
The purpose of this Qualitative Descriptive (QD) study was to describe the experience of adults hospitalized without COVID-19 during the pandemic.

Specific Aims:

1. Describe the hospital experience, including but not limited to, interactions with hospital staff, visitation, isolation, physical and emotional stressors, and the environment.

1. Identify perceived comfort needs during hospitalization and perceptions of the nurse’s role in providing comforting interventions.

1. Examine the ability to achieve physical, psychospiritual, sociocultural, and environmental comfort during hospitalization despite the required infection control measures.

The desired sample was adults who were hospitalized during the COVID-19 pandemic but were negative for COVID-19 during their hospital stay.

- Inclusion Criteria:
  - English-speaking adults over the age of 18
  - Hospitalized on a medical or surgical floor for a minimum of 2 consecutive nights after April 1, 2020
  - Negative for COVID-19 throughout their entire hospital stay.

- Exclusion Criteria:
  - Patients on isolation precautions during their hospitalization for a reason other than COVID-19
  - Patients hospitalized for greater than 10 days
Social Media Post
Screened for eligibility via email or Direct message. Interview Scheduled
Obtained Vernal Informed Consent
Completed Semi structured Interview via Zoom

Were you hospitalized during the pandemic?
I am a nurse and want to learn about your experience if you:
- Are 18 years of age or older
- Were hospitalized for at least 2 consecutive nights after 04/01/2020
- Tested negative for COVID-19 during your stay
- Are willing to participate in a zoom interview that will be approximately 1 hour-long

A $25 Gift Card will be provided. Scan the QR code, click on the link, or contact Julia Patrick at Julia.Patrick@umassmed.edu for more information

Graduate School of Nursing

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Transcribed by Rev.com
Exemplars for categories identified from the data
Ongoing research team debriefing and codes grouped into themes

Data was analyzed using conventional content analysis (Hsieh & Shannon, 2005)

Codes sorted, grouped into categories
Key thoughts noted, initial coding scheme emerged

Stored on protected drive, transcription verified, recordings deleted
Transcripts read and re-read, to gain general understanding
Participants (N=20) ranged in age from 22 to 75

<table>
<thead>
<tr>
<th>Profile</th>
<th>Participants (n)</th>
<th>Location of Hospital</th>
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<tr>
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<tr>
<td>35-54</td>
<td>4</td>
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<td>3</td>
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<td>Ohio</td>
</tr>
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<td>2-4</td>
<td>7</td>
<td>Pennsylvania</td>
</tr>
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<td>5-7</td>
<td>5</td>
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</tr>
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<td>8-10</td>
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</table>

<table>
<thead>
<tr>
<th>Previously Hospitalized</th>
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<tbody>
<tr>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
</tr>
</tbody>
</table>

I Don’t Expect the Hospital to be Comfortable

“I don't expect to be comfortable in the hospital. It's not a place that is comfortable ever.”

“I hate the hospital beds. They're super uncomfortable, so I can never get comfortable.”

“...The window [in the room] was up behind my head, really high up and it was a long, thin pane of glass and it was frosted. So there was no view to the outside world. So after about 3 or 4 days, I felt I was going crazy in this room.”

Theme 1
**I was Always Tense**

“They did give me Zoloft, which I'm still taking for anxiety because it was just too much.”

“I was very fearful. I was extremely fearful that something else was going to let loose or happen.”

“I think I was always on guard. I think I was always tense.”

“I definitely had pretty heightened anxiety. I did actually reach out to a therapist.”

---

**Wanting human connection**

“You just wanted that extra moment when the lady that delivered your lunch tray could just stand there for a moment.”

“I did not want to talk on the phone but if somebody had been sitting there, they could have just been sitting there, which is different.”

“Like in an ideal world, obviously, you know you weren't short on staff or like things like that, then yeah, like being able to like, talk to another human for a little while […] Even for like 2 minutes, it kind of just makes a little bit of a difference.”

“I was in a lot of pain after the surgery and one of the nurses sat and talked with me and helped distract me a little bit.”

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**Theme 2**

**Theme 3**
**Communication is Important**

“I was kind of used to wearing masks. But when you didn't feel good, you didn't want the mask on when you're trying to communicate to the doctors... There definitely was a barrier in that respect. It was frustrating, but you just needed a little patience to get through it.”

“And the other thing is maybe just as a nurse, when you go in to check at the beginning of a shift, introducing yourself, telling them that you're the nurse on this shift, just so you knew who it was. I didn't know from one minute to the next, who was coming in or out [...] And I never knew who my nurse was.”

Theme 4

**Nurses are Busy**

“I remember just like begging the nurse to help. I required an awful lot of attention and there really wasn't the staff to give it to me.”

“There was one day where I could tell they (the nurses) were really short staffed, and so I didn't ask for a bath that day. And things like that, because I thought, "Mm, somebody else probably needs their attention more than me.""

“I didn't even feel like the staff was there able to help me, because obviously there was a lot of other people that were there for reasons including COVID, so I just felt very isolated and not taken care of.”

“You have the nurses for emergencies, but I don't want to bother them.”

Theme 5
The time nurses spend with patients is tied to better patient health outcomes, patient satisfaction, and nurse satisfaction (Westbrook et al., 2011; Drageset & Haugan, 2021; Antinaho et al, 2015; Smeds et al., 2014).

- Some participants felt that nurses were busy and that units were understaffed, which impacted their perception of care, relationships with the nurses, and their willingness to ask for help.
- Participants described challenges of masks impeding communication, and expressed the desire for better communication with nurses. The relationship with the nurse was negatively impacted by poor communication. This aligns with the 2021 survey of patient experience that found that clinician-patient communication is an important part of the overall perception of the patient care experience (Key et al., 2021).
- Literature suggests that mask-wearing decreases non-verbal communication by limiting the ability to read facial expressions and may make communication difficult for patients (Frith, 2009).

Limitations to the study exist. Findings raise questions for further study and may be transferable to similar situations.

- More females than males (75% Female)
- Geographic diversity but 95% of participants identified as Caucasian
- Included participants with varying diagnoses limiting the ability to identify comfort needs specific to a single diagnosis
- Potential for recall bias as the variability from time of hospitalization to time of interview spanned many months
- Some participants had multiple previous hospitalizations which may have impacted their experience.
Many patients were seeking connection to others, clear communication, and a desire for greater nurse availability during the COVID-19 pandemic.

Feeling alone and isolated left patients longing for more interaction with others. Human connection matters.

<table>
<thead>
<tr>
<th>A noisy, busy and chaotic environment made it more challenging for patients to achieve relief, ease, and transcendence during their hospital stay.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeting education and research to improve patient comfort (physical, psychospiritual, sociocultural, and environmental) is needed to determine best practices for improving patient experience during hospitalization.</td>
</tr>
</tbody>
</table>

Patients faced challenges achieving comfort in the physical, psychospiritual, sociocultural, and environmental contexts.

- The impact of the hospital environment on participants’ hospital experiences is consistent with previous research that shows that the environment can influence patient comfort, anxiety, satisfaction, and health outcomes (Andrade et al., 2017; Douglas & Douglas, 2004; LaVela et al., 2016).
- Participants in this study experienced negative emotional health effects including loneliness and sadness when visitation was limited and some regretted having to deal with their illness alone.
- These findings resonate with emerging literature that has begun to identify loneliness and anxiety among patients denied visits with friends and family during the COVID-19 pandemic (Key et al., 2021; Siddiqi, 2020, Zeh et al., 2020; Drapeaux et al., 2021).
I would like to thank everyone for their support

Special thanks to:

My wonderful husband Moe, my mom Lou, and my ever-supportive family and friends

Dr. Nancy Morris, Dr. Jesica Pagano-Therrien, Dr. Rosemary Taylor

GSN Faculty

My PhD Cohort and now life-long friends

All who shared my dissertation advertisement
Dissemination Plan

The primary description of this dissertation work was submitted as a manuscript on May 26\textsuperscript{th}, 2022, to the Patient Experience Journal for review and consideration for publication.
Appendices

Appendix A

Social Media Advertisement

Were you hospitalized during the pandemic?
I am a nurse and want to learn about your experience if you:
- Are 18 years of age or older
- Were hospitalized for 2 consecutive nights between 4/1/20 and 12/31/20
- Tested negative for COVID-19 during your stay
- Are willing to participate in 1 zoom interview that will be approximately 1 hour-long

A $25 Gift Card will be provided.
Scan the QR code, click on the link, or contact Julia Patrick at Julia.Patrick@umassmed.edu for more information

Graduate School of Nursing
Appendix B
Webpage Link and Fact Sheet


If after reading this information you want to talk with me about your time in the hospital, please contact me at: Julia.Patrick@umassmed.edu to set up an interview time.

You can take part in this study if you:
- Speak English.
- Are 18 years or older.
- Were a patient in the hospital for 2 consecutive nights between April 1, 2020 and December 31, 2020.
- Did not have COVID-19 while in the hospital.
- Have access to the internet (on a phone, tablet, or computer) so we can meet via Zoom.

You cannot take part in this study if you:
- Were in the hospital for more than 10 days
- Were on contact precautions during your stay

FACT SHEET

Title: Non - COVID-19 Hospitalizations: Patients’ Experiences During the COVID-19 Pandemic.

Investigator: Julia Patrick

Sponsor: The University of Massachusetts Medical School Graduate School of Nursing

A. We are inviting you to take part in a research study.

B. Taking part in this research is voluntary. You are free to say no or to leave the research at any time. There will be no penalties or changes in the quality of the health care you receive, and you will not lose any benefits to which you are otherwise entitled.

C. The purpose of this study is to understand your experience when you were in the hospital during the COVID-19 pandemic with strict infection control policies being used.

D. If you agree to be in the study, I will interview you over zoom in a private setting of your choice where you have internet connection. I will record the audio and visual components of the interview. You may choose to disable your video camera if you prefer. Interviews may last about 1 hour.

E. There is a risk that talking about the time you were in the hospital may be upsetting to you. You can stop the interview any time and you can skip any questions you feel uncomfortable answering. Should you experience difficult emotions in relaying stories of your hospitalization,
and wish to speak to someone further, it is advised that you contact your primary care provider or the Substance Abuse and Mental Health Service Administration (SAMHSA) National Helpline at 1-800-662-HELP.

We will take steps to ensure that your information remains protected, and your name will not be connected to any information you share during the interview.

To assure confidentiality, I will not record your name during the interview but will use a code to identify all the information you share. A transcript of the interview and any personal information you share will be stored electronically on secure computer networks. These computer networks have many levels of protection.

F. There will be no links of your identity to any of the information you share. All data will be destroyed 3 years after completion of the study.

G. Taking part in this study may help us to gain knowledge about what it is like to be hospitalized during a pandemic. However, there is no direct benefit to you.

H. As a thank you for being in the study, you will receive a $25 Bank of America gift card.

I. It may be several years before the results of the research are available. If you would like us to try to reach you at that time, please let us know. We will ask for your contact information.

J. We will try to limit access to your personal information to people who have a need to review this information. We cannot promise complete privacy. The University of Massachusetts Medical School, including the Institutional Review Board (IRB) and research, billing, and compliance offices, may see your information.

In order to receive the $25 Bank of America gift card, you will need to give us your name, address, and phone number. We will then share this information with the business offices and companies that need to process the payment. If you receive $600 or more in a calendar year from being in research studies at UMass Worcester, UMass Worcester may report this to the IRS and send you a 1099 form for tax purposes. The business offices and companies will keep the information as part of their financial records. The research team will destroy this information 3 years after the study ends.

K. The University of Massachusetts Medical School does not provide funds for the treatment of research-related injury. If you are injured as a result of your participation in this study, treatment will be provided. You or your insurance carrier will be expected to pay the costs of this treatment. No additional financial compensation for injury or lost wages is available. You do not give up any of your legal rights by participating in this research.

L. If you have any questions, concern, or complaints, or think that the research has hurt you, you can talk to the Principal Investigator Julia Patrick by phone at (518) 423-0412 or via email at Julia.patrick@umassmed.edu. 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

<table>
<thead>
<tr>
<th>Conceptual Area</th>
<th>Main Question</th>
<th>Prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of being hospitalized during COVID-19</td>
<td>'Tell me about your overall experience being hospitalized during the COVID-19 pandemic?</td>
<td>- 'Tell me what a day in the hospital was like</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- How did you interact with friends and family members?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 'Tell me about your interactions with staff?</td>
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<tr>
<td></td>
<td></td>
<td>- What emotions did you feel during your stay?</td>
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<tr>
<td></td>
<td></td>
<td>- What was the hardest part of being hospitalized during the pandemic?</td>
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<tr>
<td></td>
<td></td>
<td>- How was your experience impacted by having the hospital staff wearing masks and face shield or goggles?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- What I’m hearing you say is….</td>
</tr>
<tr>
<td>The nurse’s overall role in the hospitalization</td>
<td>Describe your relationship with the nurses during your hospitalization</td>
<td>- Do you have any specific memories or stories (good or bad) related to the nursing care you received?</td>
</tr>
<tr>
<td>experience</td>
<td></td>
<td>- What did nurses do that helped you feel more comfortable?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Or what do you think the nurses could have done to make you more comfortable?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Do I understand that you felt….</td>
</tr>
<tr>
<td></td>
<td>Let’s talk about communication and how that was for you with everyone wearing PPE.</td>
<td>- Did you find communication to be challenging?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- How was it for you with everyone wearing a</td>
</tr>
</tbody>
</table>
Promoting comfort: relief, ease and transcendence

| Did you have any physical pain or discomfort (fever, itching, nausea) while hospitalized? | Tell me about having your basic needs met (eating, toileting, bathing, sleeping, pain management, nausea management (if appropriate)) | What about any challenges with:
* getting in and out of the bathroom?
* getting washed up each day?
* getting to sleep?
* getting your meals?
* getting your medicines? |

| Did you have any anxiety or fear during your hospitalization? Any concerns about spiritual or religious beliefs? | Ease is a state of feeling calm, and content. Do you feel you were at ease during your stay? Why or why not? | Were you able to get the help you needed to manage your pain? Tell me more about that. |

| Were you able to get the help you needed to manage your anxiety or fear? Tell me more about that. | Tell me about any challenges you had trying to improve your comfort? | Tell me about any challenges you had trying to decrease your anxiety or fear. |
Contact with family and friends is often comforting; given the limitations on visitors during your hospitalization how did this impact you?

How did the hospital environment contribute to your overall sense of comfort?

- What did you do to cope during your hospitalization?
- Did you make more use of the phone, face time, an IPad to stay connected with others?
- What was the hospital environment like?
- How did the environment make you feel?
- Was the furniture comfortable?
- Was the room too noisy/too quiet?
- Was the room too hot, too cold?
- Did you have privacy?
- I am hearing you say…

Recommendations for the future

What are some things you feel could have made your hospitalization a little easier for you?

- What do you wish you could have changed about your experience during hospitalization?
- What things helped you through your hospitalization that you would recommend for others?
- It sounds like your suggestions are to…..

<table>
<thead>
<tr>
<th><strong>General Probes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tell me more about that</td>
</tr>
<tr>
<td>How did that make you feel?</td>
</tr>
</tbody>
</table>