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Cover Page Footnote

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Non-COVID-19 hospitalizations: patients' experiences during the COVID-19 pandemic

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Abstract

The purpose of this Qualitative Descriptive study was to describe the experience of hospitalized adults during the pandemic who did not have COVID-19. Semi-structured interviews were conducted with 20 English-speaking adults who were hospitalized on a medical or surgical floor after April 1, 2020 and were negative for COVID-19 throughout their entire hospital stay. The 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. Conventional content analysis of the transcribed transcripts revealed five main themes related to the hospital experience: I don't expect the hospital to be comfortable; I was always tense; Wanting human connection; Communication is important; and Nurses are busy. An unpleasant environment, longing for comfort from family and nurses, a perception that the nurses were too busy, feelings of being isolated from others and the world, and experiencing fear and anxiety were all elements of the hospital experience during the COVID-19 pandemic. These findings identified a need for targeted practice, research, and education to improve patient comfort in the physical, psycho-spiritual, sociocultural, and environmental contexts. This is important as we look toward improving the overall patient experience during hospitalization.

Keywords

Patient experience, patient perception, healthcare, quality of care, nursing care, COVID-19, hospitalization, comfort needs

Introduction

Hospitalization is a stressful experience for patients and contributes to psychological distress including depression and anxiety.¹⁻³ To decrease transmission of COVID-19 within the hospital, strict infection control measures were put into place in early 2020, at the start of the pandemic, that limited interaction and increased space and physical barriers between individuals. These measures limited interactions and communication between hospital staff, patients, and visitors were limited and interactions occurred with people wearing a face mask and a face shield or goggles, altering the usual frequency and kinds of exchanges between individuals.⁴ Emerging literature suggests that hospitalization during the COVID-19 pandemic led to increased psychological distress in patients related to social isolation.⁵

The amount of time nurses spend with patients is directly tied to better patient health outcomes.⁶ A therapeutic nursing relationship is important for achieving positive health outcomes⁶ and the extent to which the nurse-patient relationship was affected by the infection control measures implemented during the COVID-19 pandemic is unknown. A decrease in physical interaction and use of Personal Protective Equipment (PPE) have been necessary to decrease the transmission of communicable diseases⁷ but it is important to understand if and how these changes

affect the comfort of patients and their overall hospitalization experience.

Patients who achieve and maintain comfort become stronger and better able to heal than patients in a state of discomfort.⁸ The Theory of Comfort conceptualizes comfort as existing in three forms: relief, ease, and transcendence.⁸ Relief is the experience of having basic needs met. Ease is the state of calm and contentment. Transcendence is the state in which the individual moves beyond the challenges they face.⁸ There are four contexts in which comfort can occur: physical, psycho-spiritual, sociocultural, and environmental.⁹ Physical comfort relates to freedom from unpleasant bodily sensations such as pain and nausea. Psycho-spiritual comfort relates to a person's satisfaction with one-self, spirituality, and meaning in life. Sociocultural comfort pertains to relationships with family and society. Environmental comfort relates to the person's external surroundings.⁹ Quality nursing care includes the assessment of patient comfort needs in these four contexts, and the provision of appropriate interventions to help patients transcend the stress of hospitalization. Understanding the experience of patients who were hospitalized during the COVID-19 pandemic can provide insight into challenges encountered in meeting comfort needs despite the infection control measures enacted during this time.

The purpose of this Qualitative Descriptive (QD) study was to describe the experience of adults who did not have COVID-19 while hospitalized during the COVID-19 pandemic. The study focused on patients' perception of having their comfort needs met despite the infection control measures in place during this time. Participants shared their hospital experiences, including but not limited to, interactions with hospital staff, visitation, physical and emotional stressors, and the environment. I identified the perceived comfort needs of patients hospitalized during the pandemic and the nurse's impact on helping the patient achieve comfort, based on Kolcaba's Theory of Comfort which guided this study.

Methods

Methodology

I used a Qualitative Descriptive (QD) design, interviewing adults who were hospitalized without COVID-19 between April 1, 2020 and December 3, 2021. The rich description provided by QD allows researchers to gather information about poorly understood experiences.¹⁰ In this study, QD allowed the generation of a comprehensive descriptive summary of the experience of having comfort needs met for 20 participants who were hospitalized during the COVID-19 pandemic.

Study Population

Purposive sampling was used to recruit adult participants who were hospitalized during the pandemic and tested negative for COVID-19 throughout their entire 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. Having broad inclusion criteria allowed for maximum variation sampling to gain varied perspectives. Exclusion criteria: Patients on isolation precautions during their hospitalization for a reason other than having a COVID-19 infection and patients hospitalized for greater than 10 days.

Setting

Interviews took place over Zoom, a secure, reliable video platform, in a confidential space selected by the participant. Participants were advised to choose a location where there was reliable internet access and where they had privacy and freedom to speak openly without distraction or interruption.¹¹

Procedure

The UMASS Chan Medical School's Institutional Review Board approved this study. Participants were recruited via an advertisement on social media and word of mouth. Those who expressed interest in participating emailed me or sent direct messages through social media. Potential participants were screened for eligibility via email or

messaging through social media and if appropriate, an interview was scheduled. After obtaining informed consent, semi-structured interviews were conducted using an interview guide that consisted of open-ended questions and prompts to be used as needed. The interviews took place and were recorded via Zoom with the participants' permission and transcribed using a paid transcription service. The interview questions focused on four main topics: 1) The overall experience of being hospitalized during the COVID-19 pandemic, 2) The nurse's role in the experience, 3) Comfort needs and the experience of having comfort needs met during the hospitalization, and 4) Recommendations on how to improve the hospital experience. Interviews were conducted until informational redundancy was achieved.¹⁰

To establish trustworthiness, I used the criteria of credibility, transferability, dependability, and confirmability.¹² To achieve credibility, I debriefed regularly with my research team of doctoral-prepared nurses, collected observations during interviews, and confirmed my understanding of content shared during each interview. To establish transferability, I consulted with my research team on the data analysis/coding process including code definitions, and the organization of codes into themes. An audit trail was kept to establish dependability. The interviews provided rich and thick data which helped establish dependability by providing the information necessary for others to review and confirm interpretations.¹⁰ I included representative quotes to demonstrate that the findings match the data based on the participants' own words.

Data Analysis

The transcriptions were analyzed using conventional content analysis.¹³ I listened to each recording and compared it to the transcription to assure accuracy. I made notes about initial thoughts while reading the transcription and developed codes for the concepts and ideas that were found. Similar ideas were consolidated into one code. Definitions were applied to the codes. Themes were identified by grouping similar codes together. Themes and codes were frequently discussed with my research team and any discrepancies were elaborated upon until consensus was reached. Descriptive statistics were run on demographic data using Excel.

Results

Twenty participants, 75% (n=15) female and 25% (n=5) male, (Table 1) took part in this study. The majority (95%) of the participants were Caucasian. Participants were from Mexico, England, and eight different U.S. states. Forty-five percent of the participants were over the age of 55 and 16 (75%) had been hospitalized previously. Participants were admitted with a variety of diagnoses including cholecystectomy, kidney failure, colostomy surgery, and

Table 1. Demographic Characteristics

Profile	Participants (n)
Age	
21-34	7
35-54	4
55-63	6
65+	3
Gender	
Male	5
Female	15
Race	
White	19
Black	1
Location	
England	1
Mexico	1
United States	
Alabama	1
Iowa	1
Maine	1
Maryland	1
Massachusetts	9
New York	1
Ohio	1
Pennsylvania	3
Nights in the Hospital	
2-4	7
5-7	5
8-10	8
Previously Hospitalized	
Yes	16
No	4

trauma following a motorcycle accident. This contributed to the varying lengths of stay (mean of 6 days, range 2-10 days).

Conventional content analysis of the transcribed transcripts revealed five main themes related to the hospital experience: I don't expect the hospital to be comfortable; I was always tense; Wanting human connection; Communication is important; and Nurses are busy.

I Don't Expect the Hospital to be Comfortable

Participants' perceptions of the hospital environment were varied and impacted their experiences of comfort. Participants had very low expectations for comfort in the hospital environment: "I don't expect to be comfortable in the hospital. It's not a place that is comfortable ever." Another participant shared: "I don't even think I have any sort of positive expectations of comfort. The bare minimum is great." The hospital environment also contributed to physical discomfort: "I hate the hospital beds. They're super uncomfortable, so I can never get

comfortable." The built environment of the hospital contributed to participants' perceived lack of connection to the outside world: "...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 out. So there was no view to the outside world. So after about three or four days, I felt I was going crazy in this room." And another participant noted: "at one point I was in a room with no windows, that wasn't too good. Couldn't tell whether it was daytime, nighttime."

The hospital environment was often described as noisy and loud. Common noise complaints were related to alarms, machines beeping, doors opening and closing, and nurses and patients talking outside their rooms, interrupting people's sleep: "I hardly slept at all because of noise outside the room. The nurses, I was right by the nurse's station. So there were a lot of beeping of machines. The nurses, on the first night, were very noisy, they were laughing. They're trying to have a good time and doors were slamming and this is at two, three, four a.m. It was so loud even with earplugs in." One participant expressed annoyance and frustration at the noise coming from the

machines in their room and the nurse's failure to quiet the noise: *"When the alarm goes off because I'm out of fluid or it needed attention, and I ring the buzzer and he (the nurse) comes down, he just said, "Oh, gosh. How in the world did you use all that?" Then he doesn't even turn the alarm off. He leaves and walks away and the alarm's still going off. It's very annoying after a period of time."*

I Was Always Tense

Participants experienced many emotions during their hospitalization including fear and anxiety, which contributed to participants feeling tense. Many expressed fear of contracting COVID-19 while in the hospital: *"There was always just the little concern in the back of my head that I might get COVID in the hospital, even though I'm quite certain that they work really hard to make sure that they and their staff and patients don't get COVID, but still I'm in a hospital in the middle of a pandemic."* Having roommates contributed to this fear of contracting COVID-19: *"So I was sort of just hoping every time a roommate came in that they didn't have COVID and that their guests didn't have COVID."* Participants felt they may have stayed at the hospital longer if it weren't for COVID-19 and were eager to get home, away from the potential exposure to COVID-19: *"And I might have said if I wasn't so worried about the state of the hospital, like, "Maybe I should stay one more day," and I'm not usually one to say that, but I did want to get home and not have to be in a hospital that's full of COVID."*

Anxiety was another common emotion experienced by participants. The anxiety prevented some from being at ease: *"I think I was always on guard. I think I was always tense."* Many participants shared that the added stress of COVID-19 made the experience of hospitalization much more anxiety-provoking: *"The whole COVID thing just made it a thousand times worse than it really would've had to be."* One participant noted their anxiety required intervention: *"They did give me Zoloft, which I'm still taking for anxiety because it was just too much."*

Wanting Human Connection

Participants longed for their families and for human connection. Participants desired the physical presence of family members: *"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"* and *"I very much needed to see my family and they couldn't come and we FaceTimed and stuff like that, but it's just not the same."* Participants described items from home which provided psychological comfort while being away from their family: *"I mean, for me, just like the blankets and the extra pillows, things that weren't from the hospital were comforting to me."* Not all participants had access to these comforting items and longed for them: *"My husband would've been there for everything, but he was restricted on the hours he could be there, where he could go, even bringing me anything. He couldn't bring me anything into the hospital. I had no comforts from home, nothing really."*

Many participants felt isolated. Lack of visitors contributed to this perception: *"So it's like this weird mix of like you know you're not alone, or at least I knew I wasn't 'cause I have supportive people in my life, but I couldn't actually like talk to them like in that same way, so it's kind of, this weird isolation I guess."* One participant described her experience: *"I was literally dropped off at the front door to have a major organ removed. And I did feel that I had good care there, but I felt my experience there was definitely, I felt a lot more isolated."* Despite being in a hospital filled with other people, participants described feeling alone and helpless: *"The worst part is I felt alone, and I didn't have anyone to help me."* Another stating: *"I felt pretty alone. First of all, because they still had limitations on visitors. My husband was the only one they would let up, and for very constructed periods of time. I felt isolated."* One participant stated: *"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. Well, you know what I mean, like not about like your blood pressure kind of thing. Uhm even for like 2 minutes it kind of just makes a little bit of a difference."* Another participant explained, *"You just wanted that extra moment when the lady that delivered your lunch tray could just stand there for a moment."*

Communication is Important

Communication with nurses and doctors was a challenge. Although many participants said they were used to mask-wearing, some described the mask-wearing as a barrier to effective communication: *"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. They were very masked up. They had a mask, they had shields, sometimes it was hard to understand them. There definitely was a barrier in that respect. It was frustrating, but you just needed a little patience to get through it."* Another challenge to mask-wearing was identified: *"I didn't realize how much we read lips until the pandemic happened."* Participants often asked for information to be repeated and had a hard time reading emotion because of the required masks: *"The biggest thing for me was definitely just that human contact, like being able to see somebody like smile at you..."*

Good communication was important to the study participants who desired more communication with their nurses, especially at change of shift: *"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."* Participants appreciated nurses communicating the plan for the day: *"And I think that was one of the things that they did, like a really nice job of was kind of coming in the morning and letting me know kind of what was on the agenda for today."* Another wished there was more communication: *"Yeah, I guess it was not being told enough that, "This is what's going on and this is what we're trying to do.""*

The Nurses are Busy

Participants shared their perception that nurses were busy and therefore they did not want to bother them: *"I was thinking they're just too busy with everything else, that my condition probably wasn't a priority condition, which I understood that. And I just let it go, figuring when they get back to me, they get back to me."* Another participant shared: *"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."* Participants described that they avoided calling for the nurse whenever possible: *"You have the nurses for emergencies, but I don't want to bother them."* Another said, *"No one ever came in and said, oh, it's time to wash now, here's a basin. I had to hunt and find what I needed to wash. Right from the start, I used the bath for myself. I got up and figured out how to get myself out of the bed, which I thought was unusual because I'm older and they often make sure that you can get up the first time to go to the bathroom, but there were no restrictions."* The lack of care from nurses was attributed to the COVID-19 pandemic: *"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."*

Some participants did not feel adequately cared for during their hospitalization; they did not feel they got the attention they felt they needed from the nurses: *"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."* At times, participants felt that requests were not consistently met: *"So she goes, oh, I think I could figure that out. I'll be back. Never saw her again. That kind of stuff was a little bit upsetting."* Others felt the response time by the nurses was too slow: *"Nobody's coming. I'm still ringing the buzzer thinking, "Where are they? I need somebody in here." Took ages for them to come, probably 10 minutes. I'm thinking, "I could have been dead on the floor if it was an emergency." Took a long time for somebody to come and see."* and: *"It would take anywhere from one to three hours to get my pain med."*

In contrast, some participants also had positive experiences with nurses. One described the nurses as attentive and good listeners: *"...they (the nurses) were good at listening. I don't like having IVs inserted into my hands or having blood drawn from my hands so they'd listen when they would try and draw blood and not draw it from the hands, or not put the IVs in the hands."* Another appreciated the time nurses spent with them: *"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."* And another noted: *"I feel like I got the best care that was available at the time."*

Discussion

Overall, the results of this study illustrate the experience of being hospitalized during the COVID-19 pandemic. An unpleasant environment, longing for comfort from family

and nurses, a perception that the nurses were too busy, feelings of being isolated from others and the world, and experiencing fear and anxiety were all elements of the hospital experience during the COVID-19 pandemic. Some aspects of the hospital experience were unique during the COVID-19 pandemic while others were consistent with pre-pandemic reports of the patient experience of hospitalization.

Kolcaba theorized that comfort within the environment is necessary to achieve overall comfort.⁸ Environmental comfort is described as the external background, including light, sound, smell, and furniture.⁹ The perceptions of the hospital environment during COVID-19 were consistent with research done in non-pandemic times that shows that the environment can influence patient comfort, anxiety, satisfaction, and health outcomes.¹⁴⁻¹⁶ The hospital environment made it difficult for participants to achieve restful sleep and limited the ability to achieve comfort. Prior to the COVID-19 pandemic, hospital-related disturbances, such as beeping machines and noise from staff, had been identified as the number one reason for sleep disturbances.¹⁷⁻²⁰ Participants in this study also complained about alarms and people talking in the halls and it impacted their ability to sleep and feel at ease. Although there have been numerous efforts to enact quiet hours and decrease the noise in hospital units,²¹ this remains an issue for patients, despite the known importance of sleep to healing and recovery.^{22,23} These findings reinforce Kolcaba's theory that light and noise can influence patient comfort in the environmental context.⁸ The importance of sleep, and the inability to achieve restful sleep while in the hospital during COVID-19, is consistent with studies performed during non-pandemic times.

Results from a quasi-experimental study of 70 pediatric patients and their caregivers in a pediatric emergency department demonstrated that an ambient environment with enhanced lighting resulted in less stress in caregivers, lower pain ratings and analgesic medication use among the patients, and higher perceived quality of care.²⁴ These findings correlate with findings of this study in which the participants felt disconnected from the world when in a windowless room, contributing to a feeling of isolation.

In addition to physical comfort needs, participants experienced difficulty meeting psycho-social comfort needs during their hospitalization. Participants described feeling tense and emotions such as anxiety and fear, which negatively impacted their experience. The presence of roommates heightened participants' fears of contracting COVID-19. In a study of patients with chronic kidney disease, patients feared contracting illness from their roommate due to their vulnerable state.²⁵ Although not unique to the COVID-19 pandemic, fear of contracting

illness is amplified by the presence of communicable disease and increased vulnerability.²⁵

The strict visitation policies that were enacted are unique to pandemic-times and contributed to patient suffering due to feelings of being alone and isolated.^{27,28} Kolcaba's description of comfort in the sociocultural context centers around relationships with family and members of society.⁸ Participants in this study who experienced strict visitation policies described feeling isolated and having a sense of being alone. These findings support a recent patient experience survey of 704 patients which reported that 2/3 of patients experienced loneliness because of visitor restrictions during the COVID-19 pandemic.²⁹ Health outcomes, such as improved mental health and decreased length of hospital stay, improve when patients can visit with family members and visitation policies are flexible.³⁰ Flexible visitation policies have been shown to increase patient rest in the ICU and provide emotional support to patients.³⁰ 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.^{27-29,31}

Participants sought comfort from items such as familiar food and pajamas from home. Similarly, in a qualitative study of patients hospitalized with and without SARS during the 2003 SARS pandemic, participants without SARS described limited access to items from home that would normally provide comfort.³² Participants also sought comfort from interactions with nurses and staff members since interactions with family were limited. A cross-sectional observational study of 188 nursing home residents identified an association between nurse-patient interaction and residents' loneliness,³³ supporting the value nurse interaction can have on patient comfort.³⁴ The provision of compassionate connected care by slowing down, being physically close to patients, and communicating openly can decrease patient suffering.³⁵ The negative opinions about the lack of physical and emotional presence of their nurses from some participants in this study warrants further examination of its potential contribution to decreased comfort. Nurses can provide compassionate care by spending time with patients and getting to know them, having empathy, and effective communication which can lessen the stress of hospitalization and illness that was amplified by the presence of a global pandemic.³⁵

Research shows that mask-wearing decreases non-verbal communication by limiting the ability to read facial expressions and may make communication difficult for patients.³⁶ In addition to masks impeding communication, participants expressed the desire for better communication

with nurses and felt poor relationships with their nurses were related to a lack of communication. This aligns with a 2021 survey of patient experience that found that clinician-patient communication is an important part of the overall perception of the patient care experience.²⁹ Participants of this study wanted nurses to communicate the plans for the day and appreciated when the plan was written on whiteboards in the room. Communication contributes to patients feeling aware, connected, and in control.³⁷ Clinician-patient communication is very important in non-pandemic times, but may be more important during pandemic-times due to the added challenges of communicating while wearing masks, and decreased interaction and connection to loved ones.

The time nurses spend with patients is tied to better patient health outcomes, patient satisfaction, and nurse satisfaction.^{6,33,34,38} 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 expressed discomfort due to delays in receiving pain medication, toileting, and bathing. Missed nursing care prevented many participants from achieving comfort in the physical context due to unmet needs and prevented nurses and patients from consistently achieving a therapeutic relationship. This aligns with the perceptions of nurses in one study who identified increased missed nursing care during the COVID-19 pandemic.³⁹

Implications for practice, research, and education

Participants in this study faced challenges achieving comfort in the physical, psycho-spiritual, sociocultural, and environmental contexts as described by Kolcaba.⁸ This study identified participants' desires for a more comfortable hospital environment, connection to the outside world, to family, and to staff caring for them, and open communication that informed them of expectations for the day. A primary responsibility of the nurse is to help patients achieve comfort in these contexts by communicating and providing appropriate nursing interventions.⁸ Further research is needed to validate interventions to facilitate comfort in all contexts.

Educators can use these findings (Table 2) to educate students and nurses about the importance of helping patients achieve comfort. Nursing students are taught to address physical comfort, such as administering symptom-alleviating medications, but findings here suggest that assessment of psycho-spiritual comfort and comfort within the environment is also important. For example, participants asked that the nurse introduce themselves at the start of each shift and communicate the plan for the shift. Educators can discuss and demonstrate

Table 2. Patient recommendations to enhance comfort

Enhancing Comfort	Participant suggested strategies
Promoting connection to families	<ul style="list-style-type: none"> • Allowing physical presence of families when possible • Facilitating access to comforts from home (pillow, blanket, own pajamas) • Encouraging/providing access to video chat when in-person visits are not possible
Promoting connection to nurses	<ul style="list-style-type: none"> • Introducing oneself to the patient as the nurse for upcoming shift • Sharing plans for the day with the patient (letting the patient know what is going on, what to expect) • Having the nurse take a few minutes to just talk, not about health topics, but about everyday things. • Having the nurse sit and talk with the patient to help with distraction • Minimize perception that the nurse is “too busy”
Promoting connection to the outside world	<ul style="list-style-type: none"> • Providing access to an outdoor window to see time of day (light or darkness), the weather (rain, snow, sunshine), day-to-day things (trees, parking lot, people coming and going) • Taking the patient on a “Hospital tour” off their unit • Bringing the patient outside for fresh air
Decreasing the noise level on the hospital unit.	<ul style="list-style-type: none"> • Silencing alarms (their own and others) • Decreasing noise from staff (talking, laughing, shutting doors) • Promptly addressing beeping alarms
Diminishing fear of contracting contagious illness	<ul style="list-style-type: none"> • Providing single rooms when possible • Cleanliness of the facility • Safety measures by staff
Enhancing communication	<ul style="list-style-type: none"> • Introducing all staff/hospital employees who come into the patient’s room • Clarifying who nurse is on each shift • Communicating clear expectations and plans for the day

compassionate nursing care that prioritizes individual patients’ comfort needs.

For some, the busy hospital environment contributed to feelings of isolation and a sense that nurses were too busy to provide care and communicate effectively. Nurses decrease patient suffering and improve the patient experience by providing compassionate care.³⁵ Finding ways to be emotionally present for patients helps to improve the nurse-patient relationship and the patient experience.³⁵ Research examining the value of informing patients of the plans for the day and the impact on anxiety and uncertainty is needed. In addition, further research to confirm many of the ideas shared by participants (Table 2) in this study is needed.

Environmental concerns were related to the comfort of the bed, noise level, and access to windows to provide a connection to the world. Although evidence-based strategies exist to reduce noise levels and increase

connection to the outside world,^{21,40} these strategies need to be utilized consistently, as many participants in this study still expressed discomfort related to the comfort of the environment. An aspect of the physical environment that is more unique to pandemic-times, is the fear brought on by shared hospital rooms which suggests that single occupancy rooms may help patients achieve psychospiritual comfort during pandemic-times by decreasing the fear of virus transmission.

Limitations

There are limitations of this study. The majority of participants were females and all were adults over the age of 18 and thus cannot speak to the experiences of children hospitalized during the COVID-19 pandemic. In addition, patients over the age of 65 have the highest rate of hospital admission at approximately 26%⁴¹ but in this study, only 10% of the participants were over the age of 65 and therefore the population does not reflect the typical

inpatient. There was little diversity in race or language and the results do not capture the experiences of non-White and non-English speaking populations. While this study captured perspectives of participants with varying diagnoses and reasons for hospitalizations, this limits the ability to identify comfort needs specific to a single diagnosis. There is also potential for recall bias as the variability from time of hospitalization to time of interview spanned many months. Lastly, variations in visitor policies across time and between hospitals may have influenced the sense of isolation and loneliness experienced by participants.

Conclusion

The COVID-19 pandemic and the associated changes in hospital policies impacted the patient experience in the hospital. Strict visitation policies added additional stress on patients who perceived they now had to handle their illness or injury alone. Participants described feeling alone and isolated, longing for more interaction with staff to fill their need for human connection. Along with infection control policies, the fear of virus transmission heightened emotions of fear, anxiety, and isolation. A noisy, busy, and chaotic environment made it more challenging for patients to achieve relief, ease, and transcendence during their hospital stay. Targeting education and research to improve patient comfort (physical, psycho-spiritual, sociocultural, and environmental) is important as we look toward improving the overall patient experience during hospitalization.

References

1. Chang B. Can hospitalization be hazardous to your health? A nosocomial based stress model for hospitalization. *Gen Hosp Psychiatry*. 2019;60:83-89. doi:10.1016/j.genhosppsy.2019.07.014
2. Gammon J. Analysis of the stressful effects of hospitalisation and source isolation on coping and psychological constructs. *Int J Nurs Pract*. 1998;4(2):84-96. doi:10.1046/j.1440-172x.1998.00084.x
3. Shuldham C, Cunningham G, Hiscock M, Luscombe P. Assessment of anxiety in hospital patients. *J Adv Nurs*. 1995;22(1):87-93. doi:10.1046/j.1365-2648.1995.22010087.x
4. Calderwood M, Deloney V, Anderson D et al. Policies and practices of SHEA Research Network hospitals during the COVID-19 pandemic. *Infection Control & Hospital Epidemiology*. 2020;41(10):1127-1135. doi:10.1017/ice.2020.303
5. Cazeau N. Social isolation: Managing psychological distress in hospitalized patients during the COVID-19 pandemic. *Clin J Oncol Nurs*. 2020;24(5):472-474. doi:10.1188/20.cjon.472-474
6. Westbrook J, Duffield C, Li L, Creswick N. How much time do nurses have for patients? A longitudinal study quantifying hospital nurses' patterns of task time distribution and interactions with health professionals. *BMC Health Serv Res*. 2011;11(1). doi:10.1186/1472-6963-11-319
7. Auerbach A, O'Leary K, Greysen S et al. Hospital ward adaptation during the COVID-19 pandemic: A national survey of academic medical centers. *J Hosp Med*. 2020;15(8):483-488. doi:10.12788/jhm.3476
8. Kolcaba K, Kolcaba R. An analysis of the concept of comfort. *J Adv Nurs*. 1991;16(11):1301-1310. doi:10.1111/j.1365-2648.1991.tb01558.x
9. Kolcaba K. A theory of holistic comfort for nursing. *J Adv Nurs*. 1994;19(6):1178-1184. doi:10.1111/j.1365-2648.1994.tb01202.x
10. Sullivan-Bolyai S, Bova C, Harper D. Developing and refining interventions in persons with health disparities: The use of Qualitative Description. *Nurs Outlook*. 2005;53(3):127-133. doi:10.1016/j.outlook.2005.03.005
11. Archibald M, Barnard A. Futurism in nursing: Technology, robotics and the fundamentals of care. *J Clin Nurs*. 2017;27(11-12):2473-2480. doi:10.1111/jocn.14081
12. Guba E, Lincoln Y. *Fourth Generation Evaluation*. Newbury Park, Calif.: Sage Publ.; 2003.
13. Hsieh H, Shannon S. Three approaches to Qualitative Content Analysis. *Qual Health Res*. 2005;15(9):1277-1288. doi:10.1177/1049732305276687
14. Andrade C, Devlin A, Pereira C, Lima M. Do the hospital rooms make a difference for patients' stress? A multilevel analysis of the role of perceived control, positive distraction, and social support. *J Environ Psychol*. 2017;53:63-72. doi:10.1016/j.jenvp.2017.06.008
15. Douglas C, Douglas M. Patient-friendly hospital environments: exploring the patients' perspective. *Health Expectations*. 2004;7(1):61-73. doi:10.1046/j.1369-6513.2003.00251.x
16. LaVela S, Etingen B, Hill J, Miskevics S. Patient perceptions of the environment of care in which their healthcare is delivered. *HERD: Health Environments Research & Design Journal*. 2015;9(3):31-46. doi:10.1177/1937586715610577
17. Wesselius H, van den Ende E, Alsmas J et al. Quality and quantity of sleep and factors associated with sleep disturbance in hospitalized patients. *JAMA Intern Med*. 2018;178(9):1201. doi:10.1001/jamainternmed.2018.2669
18. Bartick M, Thai X, Schmidt T, Altaye A, Solet J. Decrease in as-needed sedative use by limiting nighttime sleep disruptions from hospital staff. *J Hosp Med*. 2009:NA-NA. doi:10.1002/jhm.549
19. Lane T, East L. Sleep disruption experienced by surgical patients in an acute hospital. *British Journal of*

- Nursing*. 2008;17(12):766-771.
doi:10.12968/bjon.2008.17.12.30306
20. Adatia S, Law S, Haggerty J. Room for improvement: noise on a maternity ward. *BMC Health Serv Res*. 2014;14(1). doi:10.1186/s12913-014-0604-3
 21. Maidl C, Leske J, Garcia A. The influence of “quiet time” for patients in critical care. *Clin Nurs Res*. 2013;23(5):544-559. doi:10.1177/1054773813493000
 22. Knutson K, Spiegel K, Penev P, Van Cauter E. The metabolic consequences of sleep deprivation. *Sleep Med Rev*. 2007;11(3):163-178. doi:10.1016/j.smrv.2007.01.002
 23. Bonnet M, Arand D. Consequences of insomnia. *Sleep Med Clin*. 2006;1(3):351-358. doi:10.1016/j.jsmc.2006.06.004
 24. Robinson P, Green J. Ambient versus traditional environment in pediatric emergency department. *HERD: Health Environments Research & Design Journal*. 2015;8(2):71-80. doi:10.1177/1937586714566412
 25. New L, Goodridge D, Kappel J, Groot G, Dobson R. “I just have to take it” – patient safety in acute care: Perspectives and experiences of patients with chronic kidney disease. *BMC Health Serv Res*. 2019;19(1). doi:10.1186/s12913-019-4014-4
 26. Siddiqi H. To suffer alone: Hospital visitation policies during COVID-19. *J Hosp Med*. 2020;15(11):694-695. doi:10.12788/jhm.3494
 27. Zeh R, Santry H, Monsour C et al. Impact of visitor restriction rules on the postoperative experience of COVID-19 negative patients undergoing surgery. *Surgery*. 2020;168(5):770-776. doi:10.1016/j.surg.2020.08.010
 28. Key T, Kulkarni A, Kandhari V, Jawad Z, Hughes A, Mohanty K. The patient experience of inpatient care during the COVID-19 pandemic: Exploring patient perceptions, communication, and quality of care at a University teaching hospital in the United Kingdom. *J Patient Exp*. 2021;8:237437352199774. doi:10.1177/2374373521997742
 29. Petterson M. Process helped gain acceptance for open visitation hours. *Crit Care Nurse*. 2005;25(1):72-70. doi:10.4037/ccn2005.25.1.72
 30. Drapeaux A, Jenson J, Fustino N. The impact of COVID-19 on patient experience within a midwest hospital system: A case study. *J Patient Exp*. 2021;8:237437352110652. doi:10.1177/23743735211065298
 31. Maunder R, Hunter J, Vincent L et al. The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. *Can Med Assoc J*. 2003;168(10).
 32. Drageset J, Haugan G. Associations between nurse–patient interaction and loneliness among cognitively intact nursing home residents – a questionnaire survey. *Geriatr Nurs (Minneapolis)*. 2021;42(4):828-832. doi:10.1016/j.gerinurse.2021.04.001
 33. Antinaho T, Kivinen T, Turunen H, Partanen P. Nurses' working time use - how value adding it is?. *J Nurs Manag*. 2014;23(8):1094-1105. doi:10.1111/jonm.12258
 34. Bramley L, Matiti M. How does it really feel to be in my shoes? Patients' experiences of compassion within nursing care and their perceptions of developing compassionate nurses. *J Clin Nurs*. 2014;23(19-20):2790-2799. doi:10.1111/jocn.12537
 35. Frith C. Role of facial expressions in social interactions. *Philosophical Transactions of the Royal Society B: Biological Sciences*. 2009;364(1535):3453-3458. doi:10.1098/rstb.2009.0142
 36. Dempsey C, Reilly B, Buhlman N. Improving the patient experience. *JONA: The Journal of Nursing Administration*. 2014;44(3):142-151. doi:10.1097/nna.0000000000000042
 37. Smeds Alenius L, Tishelman C, Runesdotter S, Lindqvist R. Staffing and resource adequacy strongly related to RNs' assessment of patient safety: a national study of RNs working in acute-care hospitals in Sweden. *BMJ Quality & Safety*. 2013;23(3):242-249. doi:10.1136/bmjqs-2012-001734
 38. Labrague L, Santos J, Fronda D. Factors associated with missed nursing care and nurse-assessed quality of care during the COVID-19 pandemic. *J Nurs Manag*. 2021;30(1):62-70. doi:10.1111/jonm.13483
 39. Smiechowski J, Mercia M, Kemp K, Oddone Paolucci E, Santana M, Kachra R. Using design-thinking to investigate and improve patient experience. *Patient Exp J*. 2021;8(3):24-44. doi:10.35680/2372-0247.1633
 40. Agency for Healthcare Research and Quality. Trends in hospital inpatient stays by age and payer, 2000-2015. Rockville, MD; 2018.