

Teri Britt Pipe
Ann Kelly
Gail LeBrun
Don Schmidt
Pamela Atherton
Carol Robinson

A Prospective Descriptive Study Exploring Hope, Spiritual Well-Being, and Quality of Life in Hospitalized Patients

A study evaluating relationships among interventions and outcomes of hope, spiritual well-being, quality of life and length of stay in hospitalized patients at admission, discharge, and 6 weeks after discharge is described. The findings highlight the importance of presence, listening, and other caring behaviors in the patient experience.

Teri Britt Pipe, PhD, RN, is Director of Nursing Research and Associate Professor of Nursing, Mayo Clinic College of Medicine, Mayo Clinic Arizona, Phoenix, AZ.

Ann Kelly, PhD, RN, is a Retired Research Associate, Mayo Clinic Arizona, Phoenix, AZ.

Gail LeBrun, RN, is a Clinical Research Coordinator, Mayo Clinic Hospital, Phoenix, AZ.

Rev. Don Schmidt, MDiv, is President and Executive Director, Connecting Generations, Phoenix, AZ.

Pamela Atherton, MS, is a Statistician, Biostatistics, Mayo Clinic Rochester, Phoenix, AZ.

Carol Robinson, MS, APRN, BC-PCM, is an Evidence-Based Product Development Consultant, CPM Resource Center, Wyoming, MI.

Patients facing changes in their physical health are at a juncture for emotional and spiritual transition within the context of the life changes accompanying illness or injury. As nursing care focuses on the entire person, the identification of psychosocial and spiritual needs is part of the comprehensive nursing care designed with the patient. However, often the physical care and tasks seem most pressing in a busy clinical environment. A study evaluating relationships among hope, spiritual well-being, quality of life (QOL), and length of stay (LOS) in a sample (N=48) of hospitalized patients across time points spanning admission, discharge, and 6 weeks after discharge is presented.

Conceptual Framework

Jean Watson's Theory of Human Caring (Watson, 1999) is the conceptual framework for examining the constructs in this study. The theory proposes three essential aspects of caring: clinical *caritas* (*caritas* is the Greek word meaning to cherish, appreciate, give special attention to something that is precious), the transpersonal caring relationship, and the caring moment or occasion. The Theory of Human Caring emphasizes the interactive aspect of healing that occurs between nurse and patient, particularly when the nurse intentionally focuses on the caring relationship and recognizes the potential for healing to happen in mind, body, and spirit. Watson's theory supports the exploration of hope, spiritual well-being, and quality of life as dimensions that are highly relevant for nursing care.

Conceptual Definitions: Hope, Spiritual Well-Being, and Quality Of Life

Hope can be viewed as a holistic experience consisting of three primary dimensions: personal (meaning), situational (risk), and interpersonal (authentic caring) (Nekolaichuk, Jevne, & Maguire, 1999). A critical review of health care literature (Cutcliffe & Herth, 2002) revealed definitional elements of hope, including multidimensional, dynamic, central to life, future oriented, individualized, process oriented, involves goal setting, and sometimes associated with nursing. Important empirical work is emerging that focuses on specific, scientifically based interventions designed to inspire hope (Herth, 2001; Herth & Cutcliffe, 2002) and teach people thought patterns and behavioral competencies that enhance personal happiness and meaning (Foster & Hicks, 1999, 2007). Nurses are

Acknowledgment: The authors appreciate funding for this study provided by a grant from Connecting Generations and Wheatridge Ministries (#450723900).

empowered and supported by their standards of practice to be concerned with nursing diagnoses of spiritual well-being, spiritual distress, and hopelessness, as reflected in the professional model of the North American Nursing Diagnosis Association (Carpenito, 2005).

Spirituality often is defined in two major dimensions. Golberg (1998) described the vertical dimension as a relationship with the transcendent and the horizontal dimension as relationships with self, others, and the natural world. Reed (1992) described the two dimensions similarly: the vertical dimension as connectedness with a higher being with a horizontal dimension of relating to social and physical environments. Because other concepts, such as spiritual well-being, seem to share some overlap with spirituality, attention to definitional clarity is important (A.M. Dose, personal communication, January 17, 2005). Specific attributes of spiritual well-being include sense of meaning in life, harmony, faith, peacefulness, and comfort with existential concerns (McClain, Rosenfeld, & Breitbart, 2003). Research on healthy adults suggests that spiritual well-being is a central component of psychological health (McCullough & Larson, 1999).

The Centers for Disease Control and Prevention (CDC, 2007) describe quality of life as referring to a person's or group's perceived physical and mental health over time. Health professionals often used health-related quality of life to measure the effects of chronic illness in their patients to understand better how an illness interferes with a person's day-to-day life. QOL also received attention as part of the *Healthy People 2010* (U.S. Department of Health and Human Services, 2000) initiative:

QOL reflects a general sense of happiness and satisfaction with our lives and environment. General quality of life encompasses all aspects of life, including health, recreation, culture, rights, values, beliefs, aspirations, and the conditions that support a life containing these elements. More specifically, health-related QOL reflects a

personal sense of physical and mental health and the ability to react to factors in the physical and social environments.

Quality of life can be viewed from various perspectives, including the patient, the clinician, and the population; thus interpretation of clinically significant changes in quality of life is a growing area for research and clinical practice (Frost et al., 2002).

The concepts of hope, spiritual well-being, and quality of life are relevant and meaningful dimensions for patients and nurses. However, few studies have explored the trajectory of these concepts in hospitalized patients as they transition from admission to discharge and into the post-discharge period (Milstein, 2008). Additionally, the relationships among outcomes of QOL, LOS, and referrals for psychosocial care in hospitalized patients have not been well documented in the literature.

The Experience of Hospitalization: Selected Literature

Hospitalized patients may be at risk for experiencing a sense of fear and anxiety. Today's shorter hospital stays make it more challenging for the patient and health care team to form a meaningful therapeutic relationship. This transpersonal connection may be even more important as the health care environment becomes more complex and efficiency focused. Research suggests a link between how well providers know patients and how likely they are to detect and act on negative changes in patient health status (Minick & Harvey, 2003). This finding is consistent with the Theory of Human Caring (Watson, 1999).

Interpersonal communication may provide a strong indicator of the extent to which patients feel cared for, which is an aspect of the hospital experience that patients and families often remember after the care episode ends. Rogers, Karlson, and Addington-Hall (1999) reviewed questionnaires sent to families of oncology patients who died while in the hospital. While a majority of the families rated the medical and nursing care as "good" or "excellent," 59% includ-

ed at least one negative comment about the interpersonal communication skills of the staff. Not only can staff communication skills result in poor patient satisfaction, but increased levels of anxiety also may result in poor patient outcomes. A recent study of 536 patients experiencing an acute myocardial infarction found that those patients with higher anxiety levels had more in-hospital arrhythmias and ischemic complications (Moser et al., 2007).

Despite this relationship between anxiety and poor outcomes, it is not well understood which specific interventions help patients feel a sense of support from clinicians. Finnish researchers found that patients who received high amounts of social support from the staff had lower levels of fear and anxiety compared to those who received little social support (Koivula, Tarkka, Tarkka, Laippala, & Paunonen-Ilmonen, 2002). Social support included providing information about the disease or the procedure, listening to patient's fears, and treating patients with respect. More work is needed to identify techniques for creating therapeutic relationships in the hospital setting and to provide evidence of whether the techniques are meaningful from the patient and family's perspective (Milstein, 2008). The current study is an attempt to elicit better understanding of the patient experience from admission to the post-discharge period.

Purpose

The purpose of this study was to explore the relationships among hope, spiritual well-being, and QOL in hospitalized patients across the time points spanning admission, discharge, and 6 weeks after discharge. A secondary goal of this study was to provide baseline data on whether models incorporating orientation to life, hope, functional status, spiritual well-being, and patient acuity would predict QOL, LOS, and number of referrals at hospital discharge.

Hypotheses

The first hypothesis was that orientation to life, hope, spiritual well-being, and QOL would be asso-

ciated positively. The second hypothesis was that documented psychosocial needs and documented interventions would be correlated. The third hypothesis was that models incorporating orientation to life, hope, functional status, spiritual well-being, and acuity would predict QOL, LOS, and number of referrals at the hospital discharge measurement interval.

Sample

The population of interest was patients who were recovering from a serious health condition that impaired their physical function in the rehabilitation and subacute long-term recovery units of a hospital in the southwestern United States. The convenience sample consisted of all sequential patients (N=48) who met study criteria and were admitted within the recruitment period except on weekends. The selection criteria included: able to communicate without undue burden, speak and understand English, fully conscious without confusion, age 18 or over, and willing to sign a consent form.

The study was conducted in the rehabilitation and subacute hospital units. Typical diagnoses found on the rehabilitation unit included polyosteoarthritis, rheumatoid arthritis, stroke, brain injury, spinal stenosis with neurologic deficits, hip and knee replacements with co-morbidities, amputations, fractured hip, and others. The patients on the subacute unit had a variety of conditions including diabetes, orthopedic surgery of hip or knees, liver transplantation, cardiac conditions, and medical cases with co-morbidity. The patients on the subacute unit had less physical endurance than those on the rehabilitation unit. In spite of differences in diagnoses and procedures, the two populations shared the challenge of adjusting to serious, often unexpected health problems. In the judgment of the nursing leadership of the two units, the populations generally were comparable in their psychosocial needs.

Methods

The researchers used a prospective, longitudinal, descriptive

design, approved by the institutional review board. Selected data elements were collected from review of medical records of participants during their hospitalization. Research personnel were not working on the unit, administering interventions, or analyzing data. The clinical research coordinator followed a structured interview format after attending focused training sessions. The training included preventing interview bias, providing neutral probes for the open-ended questions, and using guidelines to forward appropriate requests to the patient's nurse.

Instruments

Participating patients responded on three occasions to interviews using standardized surveys that measured hope, spiritual well-being, function on activities of daily living, and quality of life. Open-ended questions also were included pertaining to aspects of care patients found most meaningful. The instruments were chosen because they were consistent with the conceptual framework of the study, represented moderate burden on participant time and energy, and demonstrated psychometric properties. Project staff administered the questionnaires within 24 hours after the patient's admission to the unit, within 24 hours before discharge, and by telephone at approximately 6 weeks after hospital discharge. If the patient could not be reached by telephone after discharge, the research staff sent the interview items and questions by mail with a return, stamped envelope.

Data from the medical record included the frequency of psychosocial/spiritual needs identified by the staff for each patient, the number of interventions and referrals to institutional resources that were intended to address the identified needs, the daily acuity rating, and demographic and health information. The study instruments and their psychometric properties were:

Orientation to Life Questionnaire. This 13-item scale (short version) measures an individual's sense of coherence, a construct

describing a person's way of seeing the world. The scale was administered only at baseline because it represents a personal trait that is thought to be stable over time and well-established by early adulthood. Strong face and content validity have been described. The scale has been used successfully in studies to measure individuals' outlook on life (Rena, Moshe, & Abraham, 1996; Santavirta, Bjorvell, Konttinen, Solovieva, & Poussa, 1996) and is in the public domain.

Herth Hope Index. This 12-item measure was devised to capture the multidimensional aspects of hope and has been used successfully to explore the nature of the relationship between hope and coping in patients with cancer. Psychometrics are acceptable and were previously published (Herth, 1992). Scoring consists of summing the total points (48 points possible); the higher the score, the higher the level of hope. The authors were granted permission to use the scale.

Functional Assessment of Chronic Illness Therapy (FACT)-Sp, Version 4 (Spiritual well-being). This subscale supplements the FACT-G and was designed to measure aspects of spiritual well-being (sense of meaning in life, harmony, peacefulness, and sense of strength and comfort from one's faith). The scale demonstrated a high level of internal consistency (Cronbach's $\alpha=0.87$) (Fitchett, Peterman, & Cella, 1996). Permission to use the scale was granted by the Evanston Northwestern Healthcare Center on Outcomes, Research, and Education.

Functional Assessment of Chronic Illness Therapy (FACT-G), Version 4 (Cella et al., 1993). This scale measures the general quality of life and is targeted to the management of chronic illness. It is the core questionnaire of a series, a 27-item compilation of general questions divided into four primary QOL domains: Physical Well-Being, Social/Family Well-Being, Emotional Well-Being, and Functional Well-Being. Each item is rated on a five-point scale ranging from zero (*not at all*) to four (*very much*). The score provides information about total quality of life as well as each dimension. Convergent and divergent

validity and test-retest reliability have been demonstrated. Sensitivity to change was confirmed by comparing three groups of cancer patients receiving cancer treatments (Cella et al., 1993). The scale demonstrated good stability ($r=0.87$) and strong internal consistency ($\alpha=0.95$) in field studies as well as in the initial testing (Gonin, Lloyd, & Cella, 1996).

Activities of Daily Living Subscale of the Memory and Behavior Problems Checklist – 1989 R. This is a nine-item subscale that can be scored separately to evaluate functional activities of daily living as distinct from behavioral symptoms. Psychometric properties and acceptable reliability and validity were previously established (Zarit & Zarit, 1983). The instrument is in the public domain.

Open-Ended Interview Questions. Six questions were developed as part of the study and were asked of participants at admission, discharge (see Table 1), and 6 weeks later as part of an open-ended interview conducted by the clinical research coordinator. Questions were validated with experienced nurses who provided review for content validity.

Approval for the study was granted through the institutional review board of the hospital and health care system. The nurse manager of the involved nursing units gave her permission and staff members were advised about the study, with care not to divulge study outcomes so staff would not be biased in their care or documentation. A clinical research coordinator screened patients for eligibility, obtained informed consent, and collected the data. The coordinator was not involved in the direct care of the patient in order to reduce response bias.

Analyses

Descriptive statistics (frequencies, means, standard deviations) were used to describe the sample (see Tables 2 & 3). The relationship of each variable (orientation to life, spiritual well-being, hope, ADL, QOL total and subscales, LOS, and the number of psychological needs) was assessed using the Pearson correlation coefficient (see Table 4).

Table 1.
Open-Ended Interview Questions

A. What were some of the hardest times or experiences you have had or are having during the rehabilitation process?
B. When did those critical issues occur?
C. How were you able to resolve or deal with these critical issues to date during rehabilitation?
D. What staff responses or resources (person [s] or other) were most helpful dealing with or resolving these “most difficult issues” (during hospitalization and since hospitalization)?
E. Were there some staff responses or resources (person[s] or other) that were offensive or not helpful in resolving or dealing with these “most difficult issues” (during hospitalization and since hospitalization)?
F. What resources, help, or approaches would you like to have had in addition to what was/is provided in the hospital?

Table 2.
Patient Characteristics

		Frequency
Age (Mean)	69.90	(12.1)
Gender (% Female)	56.25	(27/48)
Unit (%)		
Rehabilitation	25.0	(12/48)
Subacute	75.0	(36/48)

Table 3.
Mean Scores on Psychosocial Measures, Activities of Daily Living, Acuity, and Length of Stay at Admission, Discharge and 6-Weeks (Mean, SD, n)

	Admission	Discharge	6 Weeks
Hope	41.08 (4.5), 48	40.92 (4.7), 41	40.76 (4.7), 45
Activities of Daily Living	3.88 (3.5), 48	3.02 (3.0), 41	1.84 (2.4), 45
Quality of Life Physical	17.35 (4.6), 48	21.22 (5.1), 41*	23.09 (6.1), 45*
Quality of Life Social	23.25 (4.6), 48	22.51 (5.2), 41	21.09 (2.9), 45
Quality of Life Emotional	19.10 (4.3), 48	21.17 (2.9), 41	18.11 (6.5), 45
Quality of Life Functional	14.65 (5.8), 48	16.39 (5.9), 41*	21.67 (5.5), 45*
Quality of Life Total	74.48 (13.0), 48	80.80 (14.8), 41	83.96 (16.4), 45*
Spiritual Well-Being	38.98 (6.8), 48	40.15 (6.7), 41	39.13 (7.7), 45
Acuity Rate	1.98 (0.4), 48	1.73 (0.4), 48	-
Length of Stay			

* Significant compared to baseline
 $p < 0.05$

Margin of error was obtained by calculating 95% confidence intervals. Furthermore, the relationship of LOS and number of psychological needs while controlling for number of co-morbidities was assessed using the Pearson partial correlation coefficient.

Another outcome was measured by the change from the baseline scores for the FACT-G, FACT-sp, spiritual well-being, and hope scales (see Table 4). For QOL indicators, a clinically significant difference is specified as an incremental change of one half (0.5) of a

Table 4.
Correlations Between Psychosocial Measures, Activities of Daily Living, Acuity, and Length of Stay at Admission (n=48)

	Orientation to Life	Hope	Activities of Daily Living	Quality of Life	Spiritual Well-Being	Acuity	Psychosocial Needs	Referrals	Length of Stay
Orientation to Life	1								
Hope	0.459** 0.001	1							
Activities of Daily Living	-0.031 0.837	-0.039 0.797	1						
Quality of Life	0.416** 0.004	0.280 0.060	-0.355* 0.016	1					
Spiritual Well-Being	0.535** 0.000	0.418** 0.004	-0.108 0.477	0.511** 0.000	1				
Acuity	0.034 0.822	-0.148 0.325	0.176 0.241	0.170 0.259	0.114 0.451	1			
Psychosocial Needs	0.178 0.242	-0.057 0.711	0.168 0.271	-0.193 0.204	0.007 0.965	0.138 0.356	1		
Referrals	0.073 0.635	-0.157 0.303	0.416** 0.004	-0.162 0.289	0.010 0.947	0.274 0.063	0.658** 0.000	1	
Length of Stay	0.101 0.506	-0.120 0.428	0.254 0.089	-0.045 0.768	-0.080 0.596	0.200 0.172	0.585** 0.000	0.478** 0.001	1

** $p < 0.01$

standard deviation from the mean (Norman, Sloan, & Wyrwich, 2003). While controlling for acuity rankings, multivariable regression modeling also was used to assess the relationship between the length of hospitalization and the frequency of assessed psychosocial needs (see Table 5).

A sample of 48 patients provided at least an 80% chance of observing $p < 0.05$ for a test that the correlation is different from zero. The 95% confidence intervals for correlation coefficients have bounds of no more than ± 0.3 .

Results

Females composed 56.2% of the sample. The mean age was 69.9 years and the sample was predominantly White (98%). The mean number of co-morbidities was 7.8, with a mean acuity rating on admission of 1.98 (on a 3-point scale). The average LOS was 10.83 days. The measures of hope, quality of life, spiritual well-being, and functional status at baseline, discharge, and 6 weeks after discharge are shown in Table 3. The overall Quality of Life (FACT-G)

Table 5.
Summary of Multiple Regression Analysis for Variables Predicting Quality of Life, Length of Stay, and Referrals at Discharge (N=48)

Independent Variable	Dependent Variable, Score $\pm$ SE		
	Quality of Life	Length of Stay	Referrals
Orientation to Life	0.693* $\pm$ 0.309	0.252 $\pm$.188	0.646 $\pm$ 0.737
Herth Hope Scale	-1.091 $\pm$ 0.544	-0.275 $\pm$ 0.342	-1.459 $\pm$ 1.344
Activities of Daily Living	-1.003 $\pm$ 0.600	0.550 $\pm$ 0.387	4.486* $\pm$ 1.677
Spiritual Well-Being	0.251 $\pm$ 0.385	-0.191 $\pm$ 0.237	0.299 $\pm$ 0.937
Acuity	-12.149* $\pm$ 5.660	3.424 $\pm$ 3.510	15.551 $\pm$ 13.787
Constant	94.375* $\pm$ 26.483	2.396 $\pm$ 15.553	-11.257 $\pm$ 61.810
F Statistic on Model	3.402*	1.278	2.549*
Adjusted R^2	0.235	0.030	0.150

* $p < 0.05$

scores didn't rise significantly during the course of hospitalization, but rose from baseline to the 6-week followup at a level that was considered clinically significant. The functional and physical subscale QOL scores rose significantly from baseline to discharge and to 6-week follow up (see Table 3).

Correlations between the number of documented psychosocial needs and hope, spiritual well-

being, and QOL are in Table 4. At baseline, Orientation to Life was related significantly and positively to Hope ($p < 0.001$), total QOL ($p < 0.01$), and Spiritual Well-Being ($p < 0.001$). The number of psychosocial needs was correlated significantly and positively with the number of documented staff interventions/referrals ($p < 0.001$) and LOS ($p < 0.001$). Acuity at baseline was not correlated significant-

ly with any of the study variables. Hope, Spiritual Well-Being, and QOL were not correlated significantly with LOS.

Multiple regression models were built to determine the possibility of predictive relationships among the baseline levels of orientation to life, hope, functional status (ADL), spiritual well-being, and acuity. The independent variables were conceptualized as orientation to life, hope, functional status (ADL), spiritual well-being, and acuity. Dependent variables were QOL, LOS, and number of referrals. One time interval (discharge) was chosen for analysis because it represented the measurement interval that inpatient nursing could most likely impact, whereas admission and 6-week post-discharge scores would be harder for inpatient nursing care to affect. The models were significant statistically in predicting overall QOL at discharge and in predicting the number of referrals that were generated during hospitalization (see Table 5). The regression model was not significant statistically in predicting LOS.

Responses to the open-ended questions showed very positive ratings of staff responses and resources. Patients also identified family, friends, and neighbors as significant sources of strength when coping with challenges. Patients consistently identified caring behaviors, such as listening, supporting, encouraging, teaching, and advocacy, as most meaningful interventions. Very few patients identified task behaviors as particularly meaningful.

Discussion

Pertaining to the first hypothesis, hope, spiritual well-being, and QOL were correlated significantly and positively with each other at all three time intervals, which is consistent with the theoretical and empirical literature (Cutcliffe & Herth, 2002; Herth & Cutcliffe, 2002; Watson, 1999). This finding adds empirical data to support the longitudinal nature of the relationships among these variables, particularly as they relate to each other over the course of hospitalization and discharge. Strategies

to facilitate the process of learning more positive cognitive and psychological approaches to life have promising implications for helping patients restructure their cognitive frameworks in healthier patterns (Foster & Hicks, 1999, 2007). Potential synergistic relationships among hope, spiritual well-being, and quality of life represent areas for further development of evidence-based nursing interventions.

The second hypothesis was that needs and documented interventions would be correlated positively, which they were. The findings suggest that the nursing process from assessment to intervention is occurring as evidenced in the electronic nursing documentation system. By knowing their patients, nurses identified and managed needs. This process is consistent with Watson's Theory of Human Caring, which places an emphasis on knowing the patient through the transpersonal caring relationship. Findings from this study provide preliminary outcomes data supporting the relationships among psychosocial needs and both fiscal (LOS) and QOL outcomes.

The third hypothesis was that models incorporating orientation to life, hope, functional status, spiritual well-being, and acuity would predict QOL, LOS, and number of referrals at the hospital discharge measurement interval (see Table 5). The models predicting QOL and number of referrals were significant statistically, but the model was not successful in predicting LOS. Further exploration of the relationships among these variables is warranted.

Overall, study findings support the relationship among the concepts of hope, spiritual well-being, and QOL. Further, the number of psychosocial needs and related referrals are related significantly to LOS. An opportunity exists to increase awareness among nurses that simple interventions, such as listening, being present with, and offering encouragement, may have important impact on patients, not only while they are in the hospital but also after discharge. These are exam-

ples of behaviors that lead to "knowing the patient," a nursing awareness that has been linked with patient safety outcomes, including the early recognition of patient problems (Minick, 1995; Minick & Harvey, 2003).

Perhaps as nurses become more aware of the depth of caring that can be conveyed by touch or by listening to patients voice their experiences, nurses can find personal renewal and healing meaning in their practice. Additionally, nurses must recognize that caring behaviors have been linked with patient safety and prevention of harm (Minick, 1995; Minick & Harvey, 2003). Nursing documentation often highlights physical, task-oriented care more than psychosocial and spiritual caring behaviors and interventions. This creates a challenge in documenting patient outcomes related to caring behaviors.

Study outcomes have been disseminated within the authors' institution and community to highlight the role of transpersonal caring in the healing environment and mechanisms for documenting interventions more fully in the electronic environment. The hospital documentation system has been expanded to include a more focused assessment of spiritual aspects of care. In addition, an educational series was designed and delivered by and for nurses explaining the relationship between caring behaviors and patient outcomes within a theoretical context using Jean Watson's framework. Future directions for research include continuing to develop and test formal interventions that can impact hope, spiritual well-being, and QOL for hospitalized patients, even within the context of decreasing LOS.

Patients often rely on nurses to convey psychosocial and spiritual care and comfort. A great deal of the theoretical basis for nursing practice is grounded in the transpersonal relationship that regards the patient as the cherished other, the participant in the caring moment that can be a vehicle for healing at many levels (Watson, 1999). However, the nursing caring-healing behaviors that

were reported in the open-ended interview portion of this study were not well documented in the medical record and therefore could not be captured as part of the quantitative data. For instance, when asked about meaningful parts of their care, one patient reported, "The nurses were outstanding. There was one nurse... when I had this bad dream, she gently woke me and stayed with me." Other comments indicated a feeling of reassurance, a sense that staff was interested and concerned, and "they supported me and made me feel worth something, took the time with me and were kind, considerate, and patient." These caring behaviors usually were not found within the documentation. Transparency of caring behaviors presents challenging possibilities in terms of communicating and coordinating patient care.

From a broader perspective, opportunities may exist for nurses to gain a greater awareness, understanding, and ability to describe ways of being with patients that are most meaningful from the patients' perspective. Nurses' increasing awareness of and ability to document the value of their presence and caring behaviors (Watson's "way of being with someone") would add meaning and satisfaction to their work in a larger way. When nurses are conscious of the meaning of their work and how vital their way of being with patients is in the spectrum of health and healing, it may provide a strong source of career satisfaction and significance (Watson & Foster, 2003).

Limitations

One limitation of the study was that only the *documented* interventions and referrals could be counted. Many of the interventions patients listed as most meaningful (e.g., "listening") are not activities that would generally be documented by nursing staff. In addition, findings with a sample from subacute and rehabilitation units may not have generalizability to other patient populations; further study is warranted. Subjects were predominantly White, which also limits the generalizability of the find-

ings. The population was small (N = 48) and the study descriptive in nature. Measurement intervals may not have captured meaningful changes in study variables. Future studies may utilize instruments that might detect smaller differences.

Conclusions

This study provided insights based on empirical evidence about how hope, orientation to life, spiritual well-being, and QOL are linked to each other across the course of hospitalization and discharge. Interventions to address psychosocial and spiritual needs were linked with documented needs in these areas. Furthermore, psychosocial needs were associated with LOS, reinforcing the need to identify these needs early in the hospitalization, construct individualized interventions, and make appropriate referrals. Findings suggest that nursing care can impact QOL and LOS. The importance of documentation of psychosocial and spiritual caring behaviors and how they link with patient outcomes must be reinforced. ■

References

- Carpenito, L.T. (2005). *Handbook of nursing diagnosis* (11th ed.). Philadelphia: Lippincott.
- Cella, D.F., Tulsky, D.S., Gray, G., Sarafian, B., Linn, E., Bonomi, A., et al. (1993). The functional assessment of cancer therapy scale: Development and validation of the general measure. *Journal of Clinical Oncology*, 11, 570-579.
- Centers for Disease Control and Prevention (CDC). (2007). *Health related quality of life*. Retrieved May 30, 2007, from <http://www.cdc.gov/hrqol/>
- Cutcliffe, J., & Herth, K. (2002). The concept of hope in nursing 1: Its origins, background and nature. *British Journal of Nursing*, 11, 832-840.
- Fitchett, G., Peterman, A.H., & Cella, D.F. (1996, November 9). *Spiritual beliefs and quality of life in cancer and HIV patients*. Presented at the Society for Scientific Study of Religion: Nashville, TN.
- Foster, R., & Hicks, G. (1999). *How we choose to be happy*. New York: Perigee Books.
- Foster, R., & Hicks, G. (2007). *How we choose to be happy*. Retrieved May 30, 2007, from <http://www.choosetobehappy.com/about/index.html>
- Frost, M., Bonomi, A., Ferrans, C., Wong, G., Hays, R., & the Clinical Significance Consensus Meeting Group. (2002). Patient, clinician and population perspectives on determining the clinical significance of quality of life scores. *Mayo Clinical Proceedings*, 77, 488-494.
- Golberg, B. (1998). Connection: An exploration of spirituality in nursing care. *Journal of Advanced Nursing*, 27, 836-842.
- Gonin, R., Lloyd, S., & Cella, D. (1996). Establishing equivalence between scaled measures of quality of life. *Quality of Life Research*, 5, 20-26.
- Herth, K. (1992). Abbreviated instrument to measure hope: Development and psychometric evaluation...the Herth Hope Index. *Journal of Advanced Nursing*, 70, 1251-1259.
- Herth, K. (2001). Development and testing of a hope intervention program. *Oncology Nursing Forum*, 28, 1009-1016.
- Herth, K., & Cutcliffe, J. (2002). The concept of hope in nursing 6: Research/education/policy/practice. *British Journal of Nursing*, 11, 1404-1411.
- Koivula, M., Tarkka, M.T., Tarkka, M., Laippala, P., & Paunonen-Ilmonen, M. (2002). Fear and in-hospital social support for coronary artery bypass grafting patients on the day before surgery. *International Journal of Nursing Studies*, 39, 415-427.
- McCullough, M., & Larson, D. (1999). Religion and depression: A review of the literature. *Twin Research*, 2(2), 126-136.
- McClain, C.S., Rosenfeld, B., & Breitbart, W. (2003). Effect of spiritual well-being on end-of-life despair in terminally ill cancer patients. *The Lancet*, 361, 1603-1607.
- Milstein, J. (2008). Introducing spirituality in medical care: Transition from hopelessness to wholeness. *JAMA*, 299(20), 2440-2441.
- Minick, P. (1995). The power of human caring: Early recognition of patient problems. *Scholarly Inquiry for Nursing Practice: An International Journal*, 9, 303-317.
- Minick, P., & Harvey S. (2003). The early recognition of patient problems among medical-surgical nurses. *MEDSURG Nursing*, 12(5), 291-297.
- Moser, D.K., Riegel, B., McKinley, S., Doening, W., An, K., & Sheahan, S. (2007). Impact of anxiety and perceived control on in-hospital complications after acute myocardial infarction. *Psychosomatic Medicine*, 69, 10-16.
- Nekolaichuk, C., Jevne, R., & Maguire, T. (1999). Structuring the meaning of hope in health and illness. *Social Science and Medicine*, 48(5), 591-605.
- Norman, G., Sloan, J., & Wyrrich, K. (2003). Interpretation of changes in health-related quality of life: The remarkable universality of half a standard deviation. *Medical Care*, 41(5), 582-592.
- Reed, P.G. (1992). An emerging paradigm for the investigation of spirituality in nursing. *Research in Nursing & Health*, 15, 349-357.
- Rena, R., Moshe, S., & Abraham, O. (1996). Couples' adjustment to one partner's disability: The relationship between sense of coherence and adjustment. *Social Science and Medicine*, 43, 163-172.

continued on page 257

Research for Practice

continued from page 253

- Rogers, A., Karlson, S., & Addington-Hall, J. (1999). All the services were excellent. It is when the human element comes in that things go wrong: Dissatisfaction with hospital care in the last year of life. *Journal of Advanced Nursing*, 31, 768-774.
- Santavirta, N., Bjorvell, H., Kontinen, Y.T., Solovieva, S., & Poussa, M. (1996). Sense of coherence and outcome of anterior low back fusion: A 5 to 13 year follow up of 85 patients. *Archives of Orthopaedic and Trauma Surgery*, 115, 280-285.
- U.S. Department of Health and Human Services. (2000). *Healthy people 2010: A systematic approach to health improvement*. Retrieved May 30, 2007, from http://www.healthypeople.gov/document/html/uih/uih_2.htm
- Watson, J. (1999). *Postmodern nursing and beyond*. New York: Harcourt-Brace.
- Watson, J., & Foster, R. (2003). The Attending Nurse Caring Model: Integrating theory, evidence and advanced caring-healing therapeutics for transforming professional practice. *Journal of Clinical Nursing*, 12, 360-365.
- Zarit, S.H., & Zarit, J.M. (1983). *The Memory and Behavior Problems Checklist - 1987R*. University Park, PA: Pennsylvania State University.

Reprinted from *MEDSURG Nursing*, 2008, Volume 17, Number 4, pp. 247-253, 257. Reprinted with permission of the publisher, Jannetti Publications, Inc., East Holly Avenue, Box 56, Pitman, NJ 08071-0056; Phone (856) 256-2300; FAX (856) 589-7463. (For a sample issue of the journal, visit www.medsurnursing.net.)