Article

Not peer-reviewed version

What's So Great About Inpatient Rehabilitation From the Patient Experience Perspective: Content Analysis of an Appreciative Inquiry During a Bedside Experience Rounding

Tiago S Jesus *, Julia Buschbacher , Jan Struhar , Taylor Walters , Courtney Lopez , Andrea Fernandez , Kristen Gracz , Karen Colby

Posted Date: 2 July 2024

doi: 10.20944/preprints202406.2055.v1

Keywords: Patient experience; patient-centered care; patient perspective; bedside rounding; content analysis

Article

What's So Great about Inpatient Rehabilitation from the Patient Experience Perspective: Content Analysis of an Appreciative Inquiry during a Bedside Experience Rounding

Running Head: Great Patient Experiences

Tiago S Jesus [1,*], Julia Buschbacher [1], Jan Struhar [2], Taylor Walters [1], Courtney Lopez [2], Andrea Fernandez [2], Kristen Gracz [2] and Karen Colby [2]

[1] Division of Occupational Therapy, School of Health and Rehabilitation Sciences, College of Medicine, The Ohio State University, Columbus, OH, USA.
[2] Shirley Ryan AbilityLab, Chicago, IL, USA.
* Correspondence: Corresponding author **Contact Information** Tiago S Jesus, PhD, OTD (He/Him/His) The Ohio State University; College of Medicine, School of Health & Rehabilitation Sciences, Division of Occupational Therapy; tiago.jesus@osumc.edu 453 West 10th Ave. Columbus, OH 43210 Main Phone: 614-292-1706; Fax: 614-292-0210

Abstract: Background: Positive person-centered attributes of inpatient rehabilitation need to be identified from the patient perspective to be further developed and sustained. **Purpose:** To identify which attributes patients openly evoke as being great care experiences, using an open appreciative inquiry during the inpatient rehabilitation stay. **Methods:** Qualitative secondary analysis of appreciative patient comments during a bedside patient experience rounding, facilitated by a neutral party. Two independent analysts employed an inductive, summative form of content analysis. **Results:** Among 150 patients rounded, 122 provided categorizable appreciative accounts. Over two thirds of the patients (67.2%) focused on "*staff attributes*" in their great-experience accounts. Those attributes were mostly interpersonal such as being "*attentive & caring - beyond clinical duty*" and being *"encouraging (but not too hard) & reassuring"*. These interpersonal staff attributes were reported with words showing deep levels of personal significance or patient appreciation. Beyond staff attributes, the perceived quality of the "*patient care*" (31.1%) and opportunities *for "leisure and social activities"* (9.0%) were also frequently evoked. Amenities like *food* or *costumer service* were the least evoked, rarely so as an exclusive attribute (0.8% for each). **Conclusions:** The human(e) factor, especially the interpersonal qualities of staff, emerged as greatly appreciated from the patient experience perspective during inpatient rehabilitation. These experiences help identify which person-centered attributes of care might be further developed and sustained.

Keywords: Patient experience; patient-centered care; patient perspective; bedside rounding; content analysis

1. Introduction

The *patient experience* of care is part of quality and value of healthcare. [1,2] This experience refers to how patients experience and appraise valuable aspects of healthcare such as staff communication, involvement in decision-making, or preparation for discharge, among other key interactions with health providers. [3] For the broader healthcare, systematic reviews have associated better patient experience scores, with better treatment compliance, with better patient-reported physical and mental health, and finally lower healthcare utilization. [4–7] In the rehabilitation field, patient-centered care approaches (e.g., collaborative goal setting) have been for example associated to greater psychosocial outcomes (e.g., self-efficacy, emotional status, quality of life). [8–11]

Patient experiences can be systematically elicited, processed, and disseminated (e.g., relayed to providers; public reported) as one way to monitoring the *person-centeredness* of care as well as for

 doi:10.20944/preprints202406.2055.v1

informing patient-centric quality improvement (QI) activities. [3,12–14] However, a recent scoping review of the rehabilitation literature found a dearth of studies using patient experience feedback for service redesign and QI activities. [15] Among those studies, none used patient experiences at the point of care, either to timely inform immediate service recovery or for positively affecting the patient experience - while patients are receiving care (e.g. during the inpatient stay). [15]

Patient experience data is often obtained through post-discharge, externally collected surveys, which leads to relatively low response rates (e.g., 20-30%), recall bias, and often from non-representative patient samples. [16,17] Post-discharge experience survey data is valuable for benchmarking and large-scale data analysis. For example, within IRFs, standardized post-discharge patient experience data helped to identify which factors (e.g., personal issues) most contribute to better overall patient experiences, but out a response rate of 16.2%. [18] For person-centered QI purposes, these data benefits from the complement of other, more personalized forms of feedback (e.g., narratives, photovoice, open qualitative comments), [19,20] including at the point of care (e.g., during inpatient stay) – while being inclusive of a wider serviced population. [16,21–23]

In the context above, one large freestanding facility in the US developed and pilot implemented a new process to elicit near real-time patient experience feedback, designed to be then systematically relayed to providers – hence capable of enabling immediate, patient-centric service recovery. [24] Following guidance from systematically reviewed evidence, [22] this process included an in-person, mixed-methods bedside experience rounding conducted by a trained neutral party who digitally inputted both the quantitative and qualitative patient experience data. The resultant data was then relayed to the service-unit leaders - for reinforcement purposes or individual-level corrective action as needed. In short, the goal was to follow person-centered care tenets and elicit and act upon personalized patient experience feedback, toward responsiveness and adapation. [14,25]

Incorporating appreciative inquiry tenets,[15,26,27] the in-person patient experience rounding included an initial open question for each patient to describe a great care experience they wished to report back, before any suboptimal experience they could evoke for being ameliorated. In the rehabilitation literature, common 'negative' experiences during inpatient rehabilitation stays (e.g., disempowerment, boredom) have been described [28,29], but we know less from the appreciative standpoint.

Using data from a new in-person bedside experience rounding, this study aims to identify which great experiences of care patients are often evoked by patients at the point of care (i.e. during inpatient rehabilitation stay), when openly elicited from an appreciative standpoint. The findings can help build the knowledge of which attributes of care are most frequently valued and openly evoked from the patient experience perspective. Once identified, these patient-centric valued behaviors and attributes can be further developed, sustained, or rewarded in rehabilitation practice.

2. Methods

Design: Secondary, external analysis of anonymized qualitative patient comments from an in-person bedside experience rounding. That rounding was implemented during an 8-month period within a QI activity ran internally by staff or trained volunteers; the process evaluation was published elsewhere. [24] Here, our focus is on the secondary analysis of appreciative patient comments obtained during this rounding. The anonymized patient comments were qualitatively analyzed by external researchers who had no direct contact with any of the patients. As a QI activity with secondary analysis of anonymized data, it does not meet the criteria for humans subject research. We used the SQUIRE guidelines for reporting QI studies [30] and the SPQR guidelines for qualitative studies. [31]

Setting: The QI activity took place from February to September of 2023 in a large, freestanding IRF in the Midwestern USA (Shirley Ryan AbilityLab). The facility has contemporary architecture, equipment, service-delivery concept, layout, and technological environment; these factors may affect the experience of care. Specifically, the QI activity occurred within a unit focused on strengthening and endurance, i.e., not diagnostic-focused.

 doi:10.20944/preprints202406.2055.v1

Data collection: The data collection took place during the experience rounding, facilitated by trained non-attending staff or hospital volunteers. These rounds occurred shortly before the patients reached their mid length-of-stay. Following appreciative inquiry tenets, [26,27] the rounders encouraged patients to freely share any positive experiences they had encountered thus far. This invitation for positive feedback was given before posing five directed questions regarding suboptimal experiences or suggestions for improvement. During the appreciative phase, rounders actively listened to the patients' responses and immediately inputted them into a digital platform created for this purpose. Patients had the opportunity to view, listen to and revise the typed content as needed. Before being sent externally for analysis, the data were internally de-identified, including blinding of staff names.

Participants: Throughout the pilot phase, all English-speaking patients without major cognitive or communication impairments serviced by the unit over the 8-month period were included. Plans for a second phase to adapt the process for the entire patient population exist, based on the positive appraisal of the initial pilot. [24] During the 8-month implementation, all 150 eligible patients were approached and asked an appreciative question. Participants could decline or omit specific experiences.

Analysis

We conducted an inductive summative qualitative content analysis [32] to identify emerging attributes from the data without imposing preconceived frameworks. Of note, one of the analysts previously published models on person-centered rehabilitation [14] or in rehabilitation quality of care [33]; however, no attempt was made to fit the data into. Each patient quote was categorized, excluding generic (e.g., "all was great") or ambiguous statements ("great atmosphere" could be about the physical or social environment). Two external researchers performed initial open coding and axial coding independently. Disagreements were resolved through discussion. To enhance trustworthiness, a third independent analyst analyzed the results. Final changes were made based on this process, with three patient comments recategorized. The final coding structure used is provided in Supplementary Table 1. The supplementary file 2 provides the raw deidentified data and the supplementary file 3 provides the allocation of the data to the analytical categories.

Table 1. Frequency and percentage of the patient comments per major category of analysis.

Categories	Examples of attributes	Total (*n*; %)	Exclusive (*n*; %)
Staff Attributes	Interpersonal attributes and behaviors; knowledge professionalism	82; 67.2%	54; 44.3%
Patient care	Perceived quality & progress; therapy is great, enjoyable, varied, or spaced out	38; 31.1%	22; 18.0%
Leisure & social activities	Going outside; meeting new people; having fun with peers – including in group therapy	11: 9.0%	3; 2.5%
Built environment	Facility; pleasant physical environment; views.	5; 4.1%	2; 1.6%
Teamwork	Perceived alignment; shared information	5; 4.1%	2; 1.6%
Food service		6; 4.9%	1; 0.8%
Cleanliness		6; 4.9%	1; 0.8%
Bed quality		2; 1.6%	1; 0.8%
Customer service		1; 0.8%	1; 0.8%

 doi:10.20944/preprints202406.2055.v1

Quietness	1; 0.8%	1; 0.8%
Equipment (gym)	4; 3.3%	0; 0%
Room quality	2; 2.4%	0; 0%

3. Results

A total of 136 of 150 patients (90.6%) reported positive remarks about their experience of care. Among them, 122 (89.7%) provided classifiable accounts - the *corpus* under analysis.

Among those 122 patients, 70.5% (*n*= 86) evoked only one category for their great-experience accounts; the remaining provided comments fitting into two or three categories. No patient provided comments that fitted into four or more analytical categories.

1. Major Categories

Table 1 shows the frequency of patient comments per major category / attributes reported. Over two-thirds of the patients (*n*= 82; 67.2%) focused on *staff attributes* (e.g., interpersonal, professionalism), 58 of them exclusively so (44.3% of the total). In a later results section, we detail subcategories and illustrative quotes. The *patient care* process (e.g., perceived quality or experience of progress) was the second most evoked category (*n*= 40; 32.5%), inclusive of 24 mentions exclusively so (19.5% of the total).

No other categories had more than 10% of specific mentions (**table 1**). Among them, *leisure & social activities* was the most common. Patients reported that they appreciated the "*group therapy and [the] chance to meet new people*" (patient #6) and alluded to the benefits: "*it helps me mentally. I like socializing with other patients*" (patient #36). Othe social, outdoor or recreational opportunities in the garden, cafeteria, or outside of the facility were mentioned for the down time. The *built environment*, including nice views, and the *teamwork* were also evoked from the appreciative patient experience perspective. For example, one patient noted that "*you can tell there is communication between the team*" (patient #44).

Specific amenities (e.g. food service; costumer service, cleanliness) were other mentions, but with one exclusive mention each and less detailed accounts; however, if combined, these amenities would be the third most evoked category.

2. Subcategories of staff attributes

Table 2 reports subcategories of staff attributes evoked; the initial four are on interpersonal attributes.

Table 2. Subcategories of staff attributes as reported by patients (*n*= 86); ordered by prevalence, among those with specific staff attributes or behaviors reported.

Subcategories of *staff attributes*	**Total** (*n*; % of total)	**Exclusive subcategory** (*n*; % of total)
Attentive & caring – beyond clinical duty	25; 20.5%	16; 11.5%
Kind, friendly, and smiling	16; 13.1%	6; 4.9%
Encouraging (but not too hard) & reassuring	10; 8.2%	9; 7.4%
Listening and responsive to	10; 8.2%	5; 4.1%
Professional & Knowledgeable	8; 6.6%	1; 0.8%
Overall positive appraisals of staff, i.e. not subcategorized	28; 23%	10; 8.2%

Being *attentive and caring – beyond clinical duty* was the most frequent category, with 25 mentions, 16 of them just for this attribute. Illustrative comments below:

"*I think they have gone beyond their duties to make me feel comfortable*". patient #3

 doi:10.20944/preprints202406.2055.v1

"*I find the staff is paying attention to my care with things I don't even speak up about. My foot was drooping to the side and the nurse noticed and got me boots to help. I didn't even 'aask' her [emphasis]*", patient #24.

Being *kind, friendly, and smiling* was also frequently reported (*n*= 16), although only six times exclusively. The keyword "*friendly*" was common, along with mentions to kindness or smiling faces, albeit without detailed patient accounts.

Ten patients alluded to staff members being e*ncouraging (but not too hard) & reassuring*, nine exclusively so. The delicate balance of providing such encouragement is illustrated below, sometimes with notes of deep appreciation:

"*I was pushed but not forced, it wasn't like a boot camp experience*", patient #94.

"*They reassure me where I am at. If I am having a lousy day they don't push, they listen and are there but don't push me*", patient #46.

"*[He/She] tolddddddd [emphasis] me to give it some time and see how everything works (…). She was right! My stay here has been life-changing and I am appreciative*", patient #100.

"*[He/She] tells me I am doing good and beginning to walk, that's a blessing to me; they inspire you to do good*"

"*The encouragement I receive (…). It has become personal when I make accomplishments; I am wanting to make them proud and they celebrate with me and make me feel special*", patient #107.

Patients also appreciated when staff were *listening & responsive to* their needs or questions, with 10 total mentions, five exclusively so. This also involved adaptive communication and care adjustments:

"*The way they take your time and teach me. They adapt to their patients*", patient #87

"*Staff listen to me and they make adjustments to my preference*", patient #109.

Eight comments (one in exclusivity) focused on staff being *professional & knowledgeable*, intersecting their politeness and expertise. Finally, 28 patients provided comments appreciating staff but were not sub-categorizable.

4. Discussion

Under an appreciative approach, this study offers a comprehensive understanding of what patients frequently evoke as 'great' experiences, during inpatient rehabilitation. We employed a strengths-based approach to identify "what is going well", for that to be strengthened, replicated, reinforced, rewarded and/or sustained in practice. That *positive* data might complement "what is going wrong", thereby may require corrective action. [26,27,34] The patients' illustrative quotes, especially related to staff interpersonal attributes, also showed deep levels of gratitude and appreciation. Once timely collected and relayed to staff, these accounts may be useful for staff engagement, recognition and behavioral reinforcement.

Our findings highlight a notable emphasis on staff interpersonal and caring attributes, surpassing patient care and facility attributes. That partly aligns with recent *big data* analysis of post-discharge patient experience data in IRFs, [18] using data from a 10-year period, albeit based on response rate of 16.2%. For instance, Park and colleagues' analysis of post-discharge surveys suggests that a willingness to recommend the hospital as mostly determined by personal issues, such as communication with staff, pain control, and communication upon arrival. [18] These determinants were followed by physical therapy care, occupational therapy care, nursing care, discharge, and rehabilitation doctor care. [18] While overall aligned, our qualitative analysis provides a complementary dataset, with a point-of-care snapshot of patient-evoked great experiences providing illustrative accounts, especially among staff interpersonal attributes. Detailed patient accounts can be more instrumental for improvement purposes, complementing standardized post-discharge data often more useful for benchmarking purposes.[19,20]

Beyond frequently evoked, the interpersonal attributes of staff emphasized specific provider behaviors. Compared to subjective positive appraisals, specified behaviors are more easily replicable, reinforced or enacted either through data relay to providers[24] or broader scientific reporting.[14,35] Other categories evoked, by rank order, were the perceived quality of the patient care process,

 doi:10.20944/preprints202406.2055.v1

opportunities for leisure & social activities, the built environment, and teamwork. Specific amenities were less frequently evoked, and rarely exclusively so. These seemed 'nice to have' but often less fundamental than the human(e) side of care.

Among interpersonal attributes, being *attentive and caring - beyond clinical duty* was the most frequently mentioned by the patients, emphasizing the staff's genuine interest and the caring attitude. With that shown attitude, patients were likely experiencing being personally valued and cared for. [14,35,36] Patients' comments also focused on staff being *encouraging (but not too hard) and reassuring*; when this attribute was evoked, it was often exclusively so and with deep appreciation reported. The rehabilitation literature has long grappled with the delicate balance of encouraging patients without pushing too hard, a balance that includes motivating without reinforcing unrealistic expectations. [37,38] The literature has also emphasized the need for being adaptive to the situation at hand. This involves observing patient cues to discern when to push and when to stop, and instead acknowledge and reassure. [14,39] One could hypothesize that in these reported situations, staff members adeptly navigated a complex balance, seamlessly transitioning from being encouraging to reassuring and vice versa.

For staff engagement, recognition, and behavioral reinforcement, it may be important to create formal mechanisms to timely relay positive experience data to both frontline providers their service-unit leadership. [24,26] In turn, patients involved in the process evaluation of this QI activity appreciated having the opportunity and a mechanism to express and convey their gratitude to staff on their own terms [24]

In the literature, one can find some typified negative experiences in IRFs (e.g., boredom, lack of activity in the down time); [28,29,40] here, we found some symmetrical experiences from the positive side, such as joy with social activities, leisure, or engaging with peers). These findings perhaps reinforce the importance of IRFs creating opportunities for such expereinces. Socialization, in addition to valuable for many patients. can be facilitated by the environment;[41] here, socialization opportunities were partly linked to the environment (e.g., having a garden or cafeteria) or to group-based therapy. Previous studies have demonstrated that is possible to create and engage patients in creating opportunities for adding social and leisure opportunities, when those were not present by design. [40,42]

Regarding the staff's teamwork, features such as shared communication and care coordination also emerged in the great-experience accounts. While patients may not directly observe coordinating activities, they can firsthand experience whether the care or messages delivered to them are aligned, articulated, or congruent with one another. [14,33,43]

Importantly, patients responded to the same prompt, within the same IRF, with a broad spectrum of attributes that they individually experienced as great. Patients are individuals with their own set of values, preferences, lived experiences, and other human factors that make them and their experiences personal and unique. We follow the standpoint that there is a *person* beyond the *patient*, and that one-size-fits-all approach applies toward operationalizing a person-centered rehabilitation or great patient experiences. [14,25,44] Hence, the timely elicitation and relay of appreciative feedback (along with any feedback for corrective action) can be a key mechanism for a personalized, person-centered use of each patient experience's feedback for QI purposes.

Limitations

The study had the following limitations. First, the data was collected from a single facility and one unit, albeit multi-diagnostic. Features of the facility (e.g., new architecture, high-tech environment, high-rise views, widely known reputation) can affect the patient experience or the patient expectations for that experience. Hence, the results here such as frequency distribution may not be representative of other service delivery contexts. Second, appreciative inquiry tenets were but not a full appreciative inquiry approach toward strengths-based, client-engaged service. [26] Third, the analysis was focused on openly evoked positive experiences purposely biased toward *positive deviant* experiences; [35,45] those cannot be understood as the whole, balanced experience of the inpatient stay. Fourth, the secondary external analysis contributed to the analytical independence but

 doi:10.20944/preprints202406.2055.v1

implied not observing or interpretating cues from the patients during data collection, beyond the rounders' input such as elongated wording for emphasis. Finally, while we included the vast majority patients serviced by the unit during the pilot, the rounding under testing was not, at this stage, inclusive of the experiences of people with severe cognitive or communication impairments or of those unable to speak in English. Those experiences can be qualitatively different and are planned to be accommodated into future QI cycles.

Author Contributions: Conceptualization, TSJ, JS, KC; Funding acquisition, TSJ; JS Methodology, TSJ; JS; MS; Investigation: CL, AF; Software: KG. Data curation, JS, MS; formal analysis, TSJ, JB, TW; writing—original draft preparation, TSJ.; writing—review and editing: JS, KC; project administration: TSJ, JS.

Financial Support Statement: This work was funded internally by a Catalyst Quality Grant of the Shirley Ryan AbilityLab, Chicago, IL, USA.

Acknowledgments: We would like to extend our gratitude to all the participants, both patients and staff, that supported the implementation of this project and provided the data for this work.

Conflicts of Interest: The authors report no conflicts of interest. **Conflicts of Interest:** Drs Struhar, Lopez, Fernandez, Graz, and Kolby were all employees of the Shirley Ryan AbilityLab when and where the study took place. Otherwise, the authors declare no conflict of interest.

List of Abbreviations:

IRF: Inpatient Rehabilitation Facility
QI: Quality Improvement

References

1. Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century., 2001.
2. National Quality Forum. *The Care We Need: Driving better outcomes for people and communities*. 2020. Available from: https://thecareweneed.org/
3. Agency for Healthcare Research and Quality. What Is Patient Experience? Accessed December 2022, https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html
4. Navarro S, Ochoa CY, Chan E, Du S, Farias AJ. Will Improvements in Patient Experience With Care Impact Clinical and Quality of Care Outcomes?: A Systematic Review. *Medical care*. Sep 1 2021;59(9):843-856. doi:10.1097/mlr.0000000000001598
5. Goldfarb MJ, Bibas L, Bartlett V, Jones H, Khan N. Outcomes of Patient- and Family-Centered Care Interventions in the ICU: A Systematic Review and Meta-Analysis. *Critical care medicine*. Oct 2017;45(10):1751-1761. doi:10.1097/ccm.0000000000002624
6. Park M, Giap TT, Lee M, Jeong H, Jeong M, Go Y. Patient- and family-centered care interventions for improving the quality of health care: A review of systematic reviews. *International journal of nursing studies*. Nov 2018;87:69-83. doi:10.1016/j.ijnurstu.2018.07.006
7. Rathert C, Wyrwich MD, Boren SA. Patient-centered care and outcomes: a systematic review of the literature. *Med Care Res Rev*. Aug 2013;70(4):351-79. doi:10.1177/1077558712465774
8. Rose A, Rosewilliam S, Soundy A. Shared decision making within goal setting in rehabilitation settings: A systematic review. *Patient Educ Couns*. Jan 2017;100(1):65-75. doi:10.1016/j.pec.2016.07.030
9. Yun D, Choi J. Person-centered rehabilitation care and outcomes: A systematic literature review. *Int J Nurs Stud*. May 2019;93:74-83. doi:10.1016/j.ijnurstu.2019.02.012
10. Levack WM, Weatherall M, Hay-Smith EJ, Dean SG, McPherson K, Siegert RJ. Goal setting and strategies to enhance goal pursuit for adults with acquired disability participating in rehabilitation. *Cochrane Database Syst Rev*. Jul 20 2015;2015(7):Cd009727. doi:10.1002/14651858.CD009727.pub2
11. Jesus TS, Silva IL. Toward an evidence-based patient-provider communication in rehabilitation: linking communication elements to better rehabilitation outcomes. *Clin Rehabil*. Apr 2016;30(4):315-28. doi:10.1177/0269215515585133
12. Berwick DM. A user's manual for the IOM's 'Quality Chasm' report. *Health affairs (Project Hope)*. May-Jun 2002;21(3):80-90. doi:10.1377/hlthaff.21.3.80
13. Nundy S, Cooper LA, Mate KS. The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity. *Jama*. Feb 8 2022;327(6):521-522. doi:10.1001/jama.2021.25181
14. Jesus TS, Papadimitriou C, Bright FA, Kayes NM, Pinho CS, Cott CA. Person-Centered Rehabilitation Model: Framing the Concept and Practice of Person-Centered Adult Physical Rehabilitation Based on a

Scoping Review and Thematic Analysis of the Literature. *Arch Phys Med Rehabil*. Jan 2022;103(1):106-120. doi:10.1016/j.apmr.2021.05.005

15. Jesus TS, Stern BZ, Struhar J, Deutsch A, Heinemann AW. The use of patient experience feedback in rehabilitation quality improvement and codesign activities: Scoping review of the literature. *Clin Rehabil*. Feb 2023;37(2):261-276. doi:10.1177/02692155221126690
16. Boissy A. Getting to Patient-Centered Care in a Post–Covid-19 Digital World: A Proposal for Novel Surveys, Methodology, and Patient Experience Maturity Assessment. *NEJM Catalyst*. 2020;doi:: 10.1056/CAT.19.1106
17. Mercier MR, Galivanche AR, David WB, et al. Hospital Consumer Assessment of Healthcare Providers and Systems survey response rates are significantly affected by patient characteristics and postoperative outcomes for patients undergoing primary total knee arthroplasty. *PLoS One*. 2021;16(9):e0257555. doi:10.1371/journal.pone.0257555
18. Park S, Xu J, Manes MR, Carrier A, Osborne R. What Determinants Affect Inpatient Satisfaction in a Post-Acute Care Rehabilitation Hospital? *Arch Phys Med Rehabil*. Feb 2023;104(2):270-276. doi:10.1016/j.apmr.2022.08.008
19. Grob R, Schlesinger M, Barre LR, et al. What Words Convey: The Potential for Patient Narratives to Inform Quality Improvement. *Milbank Q*. Mar 2019;97(1):176-227. doi:10.1111/1468-0009.12374
20. Balbale SN, Locatelli SM, LaVela SL. Through Their Eyes: Lessons Learned Using Participatory Methods in Health Care Quality Improvement Projects. *Qual Health Res*. Aug 2016;26(10):1382-92. doi:10.1177/1049732315618386
21. Gualandi R, Masella C, Piredda M, Ercoli M, Tartaglini D. What does the patient have to say? Valuing the patient experience to improve the patient journey. *BMC Health Serv Res*. Apr 15 2021;21(1):347. doi:10.1186/s12913-021-06341-3
22. Jesus TS, Struhar J, Zhang M, Lee D, Stern BZ, Heinemann AW, Jordan N, Deutsch A. Near real-time patient experience feedback with data relay to providers: systematic review of the effectiveness. Int J Qual Health Care. 2024. In Press.
23. Graham C, Käsbauer S, Cooper R, et al. Health Services and Delivery Research. An evaluation of a near real-time survey for improving patients' experiences of the relational aspects of care: a mixed-methods evaluation. NIHR Journals Library; 2018.
24. Struhar J Gracz K, Howe T, Sheth M, Fernandez A, Lopez C, Jesus TS. Implementing a near real-time patient experience feedback process in inpatient rehabilitation: mixed-methods process evaluation informed by the Normalization Process Theory. *Int J Health Plann Manage*. 2024; In press.
25. Kayes NM, Papadimitriou C. Reflecting on challenges and opportunities for the practice of person-centred rehabilitation. *Clin Rehabil*. Aug 2023;37(8):1026-1040. doi:10.1177/02692155231152970
26. Trajkovski S, Schmied V, Vickers M, Jackson D. Using appreciative inquiry to transform health care. *Contemp Nurse*. Aug 2013;45(1):95-100. doi:10.5172/conu.2013.45.1.95
27. Sandars J, Murdoch-Eaton D. Appreciative inquiry in medical education(). *Med Teach*. Feb 2017;39(2):123-127. doi:10.1080/0142159x.2017.1245852
28. Luker J, Lynch E, Bernhardsson S, Bennett L, Bernhardt J. Stroke Survivors' Experiences of Physical Rehabilitation: A Systematic Review of Qualitative Studies. *Arch Phys Med Rehabil*. Sep 2015;96(9):1698-708.e10. doi:10.1016/j.apmr.2015.03.017
29. Kenah K, Bernhardt J, Cumming T, Spratt N, Luker J, Janssen H. Boredom in patients with acquired brain injuries during inpatient rehabilitation: a scoping review. *Disabil Rehabil*. Nov 2018;40(22):2713-2722. doi:10.1080/09638288.2017.1354232
30. Ogrinc G, Davies L, Goodman D, Batalden P, Davidoff F, Stevens D. SQUIRE 2.0 (Standards for QUality Improvement Reporting Excellence): revised publication guidelines from a detailed consensus process. *BMJ Qual Saf*. Dec 2016;25(12):986-992. doi:10.1136/bmjqs-2015-004411
31. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. Sep 2014;89(9):1245-51. doi:10.1097/acm.0000000000000388
32. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res*. Nov 2005;15(9):1277-88. doi:10.1177/1049732305276687
33. Jesus TS, Hoenig H. Postacute rehabilitation quality of care: toward a shared conceptual framework. *Arch Phys Med Rehabil*. May 2015;96(5):960-9. doi:10.1016/j.apmr.2014.12.007
34. Galvin KT, Pound C, Cowdell F, et al. A lifeworld theory-led action research process for humanizing services: improving "what matters" to older people to enhance humanly sensitive care. *Int J Qual Stud Health Well-being*. Dec 2020;15(1):1817275. doi:10.1080/17482631.2020.1817275
35. Terry G, Kayes N. Person centered care in neurorehabilitation: a secondary analysis. *Disabil Rehabil*. Aug 2020;42(16):2334-2343. doi:10.1080/09638288.2018.1561952
36. MacLeod R, McPherson KM. Care and compassion: part of person-centred rehabilitation, inappropriate response or a forgotten art? *Disabil Rehabil*. Oct 30-Nov 15 2007;29(20-21):1589-95. doi:10.1080/09638280701618729

37. Bender AA, Burgess EO. Constructing Recovery Narratives: Experiences and Expectations Following Spinal Cord Injury. *Rehabil Nurs*. Sep/Oct 2020;45(5):254-262. doi:10.1097/rnj.0000000000000202
38. Plant SE, Tyson SF, Kirk S, Parsons J. What are the barriers and facilitators to goal-setting during rehabilitation for stroke and other acquired brain injuries? A systematic review and meta-synthesis. *Clin Rehabil*. Sep 2016;30(9):921-30. doi:10.1177/0269215516655856
39. Gibson BE, Terry G, Setchell J, Bright FAS, Cummins C, Kayes NM. The micro-politics of caring: tinkering with person-centered rehabilitation. *Disabil Rehabil*. Jun 2020;42(11):1529-1538. doi:10.1080/09638288.2019.1587793
40. Jones F, Gombert K, Honey S, et al. Addressing inactivity after stroke: The Collaborative Rehabilitation in Acute Stroke (CREATE) study. *Int J Stroke*. Aug 2021;16(6):669-682. doi:10.1177/1747493020969367
41. Killington M, Fyfe D, Patching A, et al. Rehabilitation environments: Service users' perspective. *Health Expect*. Jun 2019;22(3):396-404. doi:10.1111/hex.12859
42. Clarke D, Gombert-Waldron K, Honey S, et al. Co-designing organisational improvements and interventions to increase inpatient activity in four stroke units in England: a mixed-methods process evaluation using normalisation process theory. *BMJ Open*. Jan 26 2021;11(1):e042723. doi:10.1136/bmjopen-2020-042723
43. Sinclair LB, Lingard LA, Mohabeer RN. What's so great about rehabilitation teams? An ethnographic study of interprofessional collaboration in a rehabilitation unit. *Arch Phys Med Rehabil*. Jul 2009;90(7):1196-201. doi:10.1016/j.apmr.2009.01.021
44. Barnett A, Ball L, Coppieters MW, Morris NR, Kendall E, Campbell KL. Patients' experiences with rehabilitation care: a qualitative study to inform patient-centred outcomes. *Disabil Rehabil*. Apr 2023;45(8):1307-1314. doi:10.1080/09638288.2022.2057597
45. Hudak ML, Graves A, Reichelt KA, et al. What makes a positive deviant: utilizing common themes in best practice stroke hospitals to influence institutional quality improvement. *Am J Med Qual*. Mar-Apr 2014;29(2):170. doi:10.1177/1062860613516249