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A Qualitative Study of Difficult Nurse-Patient Encounters in Home Health Care

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The purpose of this study was to explore nurse-patient encounters from the perspective of the home health care registered nurse. A qualitative descriptive design was used to collect data from a purposive sample of 20 nurses from Connecticut, Massachusetts, and Rhode Island currently or previously employed as a home health care nurse. Four themes and 1 interconnecting theme emerged from the data: objective language; navigating the unknown; mitigating risk; looking for reciprocality in the encounter; and the interconnecting theme of acknowledging not all nurse-patient encounters go well. Three types of encounters—constructive, nonconstructive, and destructive—were defined. **Key words:** *constructive encounters*, *difficult encounters*, *home care*, *home health care*, *human-to-human relationship*, *mitigating risk*, *nonconstructive encounters*, *nurse-patient encounters*, *reciprocality*, *reciprocity*

VIOLENCE against nurses was recognized as 1 of the 3 top priorities confronting the nursing profession 8 years ago when nurses were noted to be "among the most assaulted workers in the American workforce."[1(p2)] Patients are reported to be the leading perpetrators of violence against nurses,[2] with an increasing incidence of violence documented in acute care[3-5] and home health care (HHC).[6,7] HHC is hospital-level care delivered to individuals in their home by professionals such as registered nurses (RNs) with the objective of maintaining or enhancing the individual's quality of life and functional status.[8] Should a difficult situation arise, unlike a hospital or outpatient health care setting, RNs in HHC do not have on-site support of other nurses, support staff, administration, or security. Most of the research on difficult patient encounters is limited to interactions between physicians and patients in clinics or office settings.[9-16] Understanding the context of nurse-patient encounters and the cues an encounter is not going well is critical to ensuring nurse safety.

BACKGROUND AND SIGNIFICANCE

The literature on difficult patient encounters evolved from early writings on difficult patients. The difficult patient has been described as someone whose emotional, physical, or emotional and physical needs are not met.[17] Difficult patients have been categorized as "hateful patients," with descriptors such as "dependent clingers, entitled demanders, manipulative help-rejecters, and self-destructive deniers."[18(p883)] They have been described as "heartsink,"[19(p528)] "blackholes,"[20(p530)] and "bothersome."[21(p1340)] Patients with an

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Statements of Significance

What is known or assumed to be true about this topic:

Home health care registered nurses provide hospital-level care to patients in their homes. As providers, insurers, and consumers attempt to contain costs in response to changes in health care benefits, it can be anticipated that more patients will be receiving health care in the home setting. It is the norm for the home health care registered nurse to be alone in a home with a patient and possibly 1 or more caregivers. Prompt recognition by the home health care registered nurse that a patient or caregiver encounter is not going well is critical to ensuring nurse safety.

What this article adds:

This article provides an in-depth description of patient encounters from the perspective of Connecticut, Massachusetts, and Rhode Island registered nurses currently or previously employed as a home health care nurse. The specific strategies these nurses utilize to navigate the unknown, promote reciprocality and positive reciprocity, and mitigate risk are reported. Three types of home health care registered nurse-patient interactions emerged from the data, with constructive encounters the norm and nonconstructive or destructive encounters less frequent. Definitions for constructive, nonconstructive, and destructive encounters are proposed.

underlying psychiatric diagnosis, alcohol abuse, substance abuse, or a combination of 1 or more, are frequently labeled as difficult and associated with encounters reported to be difficult.[11,12,15,22] The difficult patient has been defined as "a problem of relationship, one in which the patient and physician fail to reach mutual understanding at one of a variety of levels."[23(p286)] Recent literature supports moving beyond the description of patients and provider characteristics to exploring what occurs during provider-patient interactions perceived as difficult.[13,15,16,24-27]

Only 1 nursing study was found that specifically explored the origins and context of difficult encounters, and that was from the perspective of nurses and patients on an adult medical unit in a Canadian hospital.[27] The specific aims were to explain the context of the nurse-patient encounter, with the conclusion that the length of time a nurse and patient knew each other and the effort needed to reconcile any differences impacted their relationship.[28] The presence of family members, access to supplies, coworkers, design of the work area, the reputation of a unit, and staffing patterns contributed to or minimized the potential for difficult encounters.[28] In contrast to the limited nursing literature describing nurse-patient encounters as difficult, considerable research documents an incidence of violence against nurses in a variety of practice settings with verbal or physical abuse often reported as the first sign of a problem.[3-7,29]

One of the earliest studies examined actual and perceived risks of violence by hospital in the home (HITH) nurses in Victoria, Australia.[30] This cross-sectional pilot study included 35 Victorian HITH nurses (12.3% of the Victorian HITH nurse population in 1998). More than half of the respondents (54.3%) reported a sense of threat during their work as an HITH nurse. They reported feeling threatened by the unknown and the environment (31.4%), being out at dark (22.9%), and by patients, family members, or other residents (22.9%).[30] In an American study[6] of HHC RNs (N = 738), 63% of the respondents (n = 465) reported 1 or more violent exposures, and 19% reported 2 or more exposures (n = 140). Violent exposures were self-reported experiences of "verbal abuse, threat of physical harm, actual physical assault, or threat of theft/damage to car."[6(p366)] Another American study,[7] assessed the risk of violence toward staff during home visits and found that 80 out of 130 (61.4%) HHC staff (60% RNs, 38% aides, physical and speech therapists, social workers, and social worker assistants) reported

being yelled at, shouted at, or sworn at. Five (3.8%) respondents reported an assault requiring an emergency department or physician evaluation in the past 12 months. Twenty-one respondents (16.2%) reported being threatened without physical contact in the past month. Eight (6.5%) reported visiting patients with a history of assault or violence at least monthly within the previous 12 months, and 18 respondents (15.4%) reported they receive information about a patient with a history of violent behavior at least monthly.[7]

Although incidences of patient verbal and physical abuse of nurses have been reported, [3-7,29] an incidence of difficult encounters has not been specifically documented in the nursing literature. In contrast, primary care physicians reported 1 out of 6 patient encounters (15%) as difficult.[12] Three other studies with primary care physicians had similar findings, with incidence of difficult encounters ranging from 10% to 20%.[11,13,14] Similarly, in a cross-sectional study of 20 psychiatrists, 15% of patient encounters were rated as difficult.[15] A higher incidence of difficult encounters (38.8%) was reported in an Israeli study of primary care physicians.[31] Data were collected from 7 focus groups (N = 57), and videotapes of 291 physician-patient encounters explored the incidence and types of physician-patient conflicts, defined as "any disagreement (expression of a difference of opinion) by the patient or doctor."[31(p95)]

The term *difficult encounter* has been used in literature reviews,[26,32,33] in studies that examined the origins or characteristics of difficult physician-patient,[9-15,27,28,34] and in articles that explored the discourse surrounding such encounters.[21,24,25,35-37] There is, however, no consistent or standard definition of what a difficult encounter actually is. No research-derived, evidence-based, or even expert-consensus definition of a difficult encounter was found in the literature. The specific factors associated with nurse-patient interactions that may trigger or alleviate an encounter that is not going well have yet to be clearly identified. Prompt recognition of cues that an encounter is not going well and may be turning difficult or violent is a critical skill for nurses in all practice settings, but particularly for HHC RNs who practice autonomously outside the walls of traditional health care facilities. These gaps in the literature prompted the need for further study.

THE STUDY

A qualitative descriptive study was conducted to explore nurse-patient encounters that did not go well from the perspective of HHC RNs. The research questions were: (1) What makes a nurse-patient encounter in the home difficult? (2) Are there cues that HHC RNs associate with an encounter turning difficult? (3) Is there anything HHC RNs do to prevent or mitigate difficult encounters? In addition, one of the study goals was to propose an empirically informed definition of what constitutes a difficult encounter for HHC RNs.

THEORETICAL FRAMEWORK

Travelbee's human-to-human relationship model[38] guided the literature review, influenced the development of the interview guide, and informed analysis of the data. Travelbee differs from other nurse theorists in that she attributed labels such as nurse and patient as contributing to stereotypes that hindered the development of human-to-human relationships. The words "patient" and "nurse" were used solely to communicate her theory. The patient is a human being or "ill person."[38(p17)] The nurse is a human being with the knowledge and skills to assist the ill human being. Travelbee described the human-to-human relationship as a "reciprocal process," with the nurse taking "responsibility for establishing and maintaining the relationship."[38(p124)]

Travelbee[38] proposed 5 phases (Figure) beginning with (1) the original encounter between nurse and patient, followed by a phase of (2) appreciation for emerging identities, progressing to evidence of (3) empathy

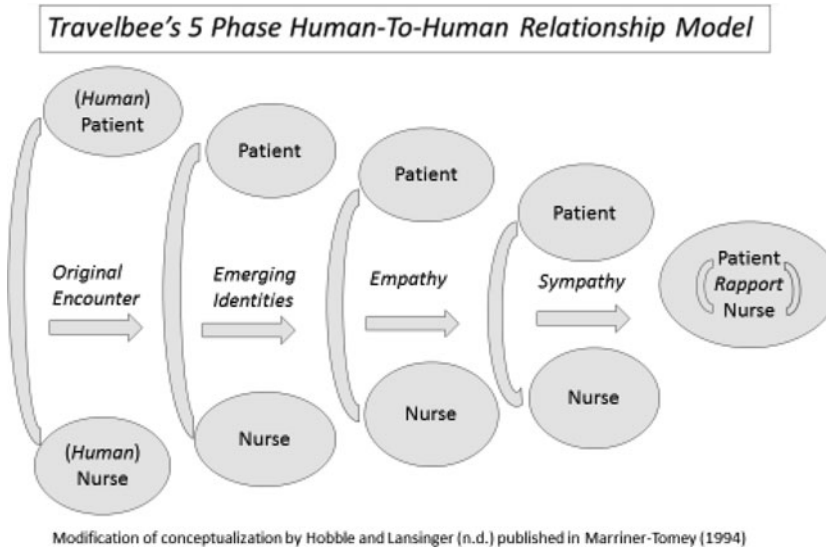

Figure. Schematic conceptualization of Travelbee's human-to-human relationship model.

followed by (4) sympathy, all leading to (5) rapport or a human-to-human relationship that is strengthened with repeated nurse-patient encounters. Inferences and value judgments may surface during the original encounter. Bonds and appreciation for the uniqueness of each human being develop during the emerging identities phase. Travelbee[39] described empathy as "an intellectual and, to a lesser extent, emotional comprehension of another person, important and desirable because it helps us to predict that person's behavior and to perceive accurately his thinking and feeling."[39(p68)] Empathy is viewed as "the forerunner of sympathy."[39(p68)] Sympathy, in contrast, is described as "a desire, almost an urge, to help or aid an individual in order to relieve his distress."[39(pp68-69)] According to Travelbee, rapport, "a particular way in which we perceive and relate to our fellow human beings,"[40(p70)] is the goal of the original encounter and the final phase of the human-to-human relationship.

Hobbie and Lansinger's conceptualized Travelbee's human-to-human relationship model[41] as a pyramid starting at the base with original encounter with patient connected in a half circle connected by a line to nurse in a half circle. The circle gradually closed to mark progression through the next 3 phases, concluding with rapport at the apex and the patient and nurse enclosed within the circle. However, the pyramid schematic design implies a hierarchal order of the 5 phases and does not illustrate forward progression as described by Travelbee.[38] This author suggests a modification such that the 2 human beings (nurse and patient) involved in the encounter are depicted in individual but connected circles, with the entire pyramid schematic rotated horizontally (Figure). This modification illustrates a reciprocal relationship with the bond between nurse and patient becoming closer with progression through each of the 4 phases until there is, as proposed by Travelbee, a human-to-human relationship or rapport. The human-to-human relationship model[38] was used throughout the study development and considered again during data analysis.

METHODS

Recruitment

Approval for this study was obtained from the university's institutional review board. An invitation with a brief description of the study

was forwarded by e-mail or in person to select visiting nurse and state nursing associations located in Connecticut, Massachusetts, and Rhode Island with the request that the study invitation be forwarded to the organizational e-mail of HHC RNs. Even though caution with this approach is recommended because "institutions always put their best foot forward in public,"[42(p91)] the recruitment of potential study participants from organizations provided access to a diverse sample of HHC RNs. The initial response rate was slow and a secondary recruitment strategy was employed. The study invitation was forwarded by e-mail to 12 HHC RNs known to the nurse researcher, who were requested to share the study invitation in person or by e-mail with no more than 5 HHC RNs not known or not well known to the nurse researcher. Inclusion criteria included (1) licensed RNs, (2) 18 years or older, (3) previous or current employment as an RN in HHC, and (4) ability to understand, read, and write English. RNs not currently working in HHC were included in the study because of the possibility a patient encounter may have influenced the RN's decision to work in another setting.

As participants were recruited, an effort was made to maximize range and variance in age, gender, and demographic characteristics. The dual recruitment strategy led to a diverse group of 20 HHC RNs living in Connecticut, Massachusetts, and Rhode Island interested in the study. A purposive sample of 20 HHC RNs (Connecticut = 7; Massachusetts = 11; Rhode Island = 2) met with the nurse researcher to learn more about the study and all consented to participate. Fourteen study participants were recruited from organizations and 6 were recruited through HHC RNs. Fifteen RNs currently work in HHC and 5 previously worked in HHC. Consistent with known demographics in nursing,[43] the majority of the sample described themselves as Caucasian or white. The mean age of 52 years was slightly over the reported mean age of 50 years for employed RNs[44] (Table 1). Interviews were completed between November 2014 and June 2015.

Data collection

Open-ended, 1-on-1 interviews were conducted in private in the nurse researcher's car, the home of the HHC RN, or in a library conference room. A semistructured interview guide was used, and all interviews began with the same first question. Each participant was asked to reflect upon their experiences as an HHC nurse and describe a visit with a patient that did not go well. Additional questions were asked to discern the characteristics of the encounter, any training or education the RN had to prepare for encounters that did not go well, and a term the RN would use to identify or label encounters that did not go well. If not shared by the participant, probing was done to explore how the patient encounter and interaction evolved, cues the HHC RN recognized during or in retrospect about an encounter that did not go well, and strategies the HHC RN used to prevent or mitigate such encounters. The term *difficult* was deliberately omitted from the study invitation, consent form, and the first interview question to prevent introducing the term to study participants and to explore whether it emerged from the data itself.[45] Notes were taken during each interview and all study participants gave permission for digital recording.

Interviews lasted approximately 60 to 90 minutes. After the interview, each participant was asked to complete a demographic data form. The data were collected after the interviews to prevent the potential impression to participants that the nurse researcher was seeking short, factual responses instead of detailed descriptions of their experiences.[45] There was no compensation for participation or reimbursement for travel expenses. The primary risk to participation was the potential for emotional distress related to describing their experiences and potential loss of anonymity. All participants were provided with contact information for counseling services to seek out if they felt it necessary. This approach standardized the process for sharing contact information for counseling services, eliminated judgment by the

Table 1. Participant Demographics (N = 20)

Characteristics	n (%)	Mean (Range)
Age		52 (23-66)
Years worked as HHC RN		14 (0.4-33)
Years licensed RN		24 (0.6-45)
Gender		
Female	17 (85)	
Male	3 (15)	
HHC primary position	13 (65)	
Employment status		
Not working HHC	5 (25)	**Majority**
Per diem	2 (10)	• Self-described as female (85%) and Caucasian (50%) or white (35%)
Part time	2 (10)	
Full time	11 (55)	
Education level		• Lived in Massachusetts (55%) with others living in Connecticut (35%) and Rhode Island (10%)
Diploma in nursing	1 (5)	
Diploma with masters in nonnursing field	2 (10)	
Associate degree nursing	3 (15)	• Recruited from organizations (70%)
BSN	9 (45)	
BSN with bachelors in other field	2 (10)	• Currently working in HHC (75%)
Masters of science in nursing	3 (15)	

Abbreviations: BSN, bachelor science of nursing; HHC, home health care; RN, registered nurse.

researcher as to which participants needed the information, and ensured participants who did not feel comfortable asking received the information.[46]

INTERPRETATION AND ANALYSIS

The nurse researcher demonstrated credibility,[42,47] as well as dependability and confirmability.[48,49] The majority of participants were recruited through organizations, and the data reflected the experiences of HHC RNs from more than 1 organization. Interviews were conducted by a clinically experienced RN with acute care, HHC, and leadership experience who looked "to identify the case that [would] likely upset [her] thinking."[42(p87)] The nurse researcher participated in ongoing peer debriefing with her dissertation committee chair at the university, intermittent meetings with her dissertation committee, and maintenance of an audit trail, as suggested by Lincoln and Guba.[49] Specifically, the audit trail included electronic code logs, a data document matrix, and a reflexivity journal.

All de-identified digital and text files were stored on a password-protected encrypted drive at the university. Study participant confidentiality was maintained by assigning a pseudonym from a published list of first names prior to each interview. Immediately following each interview, all digital recordings and notes were labeled using the assigned pseudonym. Pseudonyms were used in written notes taken during interviews, on the demographic data form, transcripts of interviews, and study logs. Data collection and analysis constituted an iterative process.[50] Reoccurring topics that emerged during interviews were explored in subsequent interviews to validate and amplify data.[47]

In qualitative descriptive, the preferred method for data analysis is qualitative content analysis (QCA). QCA is a data-derived[51] inductive approach[52] recommended for the analysis of multifaceted and poorly understood

phenomena.[53] A combination of conventional QCA,[53] modifying and categorizing,[54(p8)] and constant comparative method[55,56] was used to analyze data. A professional transcriptionist with the intent to adhere to naturalistic transcription transcribed the digitally recorded interviews. The transcribed interviews were checked against the digital recordings for accuracy of content by the nurse researcher. For presentation purposes, the nurse researcher modified participants' quotes by correcting grammar and removing irrelevant token responses. Early codes were derived from field notes and developed with more in-depth analysis of the transcribed interviews. Each transcribed interview was coded electronically within the document itself using the highlight and track changes features of Microsoft Word. An active-code log, emerging-themes log, and incidence log were created in Microsoft Excel. A memo log was created in Microsoft Word. After each interview was coded, primary and subcodes were transferred to the active-code log. New codes were numbered and reoccurring codes were highlighted in different colors to illustrate frequency.

As analysis continued, subcodes were added, revised, and shifted between primary codes, and a few were listed under more than 1 code. The emerging-code log provided a concise, color-coded spreadsheet of the number of times subcodes emerged from 2 or more interviews. The memo log was created after initial coding was completed. The memo log consisted of 9 individual tables with the primary codes that were emerging as the major themes of the study. Subcodes, salient quotes, and nurse researcher reflections were transferred from the comments section of each transcribed interview to the assigned row within the table. Coding was completed manually and was an iterative process. The methodical approach organized the large volume of data for in-depth analysis and illustrated saturation in information. Analysis involved moving between the transcripts of individual interviews, the active-code log, and the memo log to "codeweave" the data into paragraph form.[54(p187)] The study research questions guided the analysis.

RESULTS

Four themes and 1 interconnecting theme relevant to understanding what occurs during encounters between HHC RNs, patients, and caregivers emerged from analysis of the data.

Theme 1: Objective language

Overall, HHC RNs voiced preference and need for objective, nonjudgmental language to describe patient encounters. The term *difficult encounter* did not resonate with this sample of HHC RNs. The HHC RNs rarely used the term *difficult* when referring to patients or encounters with patients, and this was purposeful. Sophia stated, "You try not to ever use the word difficult patient." Instead, HHC RNs were more comfortable using *difficult* to describe a task or something that had occurred that made it hard for them to complete the patient's care or at a minimum accomplish "at least one small goal."

Subtheme 1A: Use of the word "difficult" by HHC RNs

The term *difficult* was perceived as subjective and as Aiden explained, "What's difficult for you is not difficult for me." Although HHC RNs wanted to know whether a patient encounter was perceived as difficult by another provider involved in the patient's care, simply being told this was not enough. Chloe stressed that it is important to inform the HHC RN why the encounter was perceived as difficult because "What's not written there [medical record] can hurt me." HHC RNs felt the term *difficult* does not fully capture what occurs during nurse-patient encounters. The term *difficult* was perceived as negative, vague, and subjective.

Subtheme 1B: Use of the word "challenging" by HHC RNs

HHC RNs tended to use the term *challenging* to describe personalities, behaviors, and environments. The term *challenge* was perceived as positive, hopeful, less task- or skill-focused, and not as judgmental as the term *difficult*. Madison explained, "I think the word difficult is shunned, and I think that we're programmed to use the word challenged because if you say difficult . . . people perceive that as you judging the patient." Challenging encounters were perceived by HHC RNs to require more planning, preparation, and effort. Although the majority of HHC RNs preferred the term *challenge* to *difficult*, the term *challenge* was not perceived as any more objective or descriptive than *difficult*.

Subtheme 1C: No standard phrase to alert others to encounters that do not go well

When directly asked about an alternative term to communicate or document encounters that do not go well, all the HHC RNs paused to reflect and offered a range of terms such as *complicated*, *nontherapeutic,* or described a specific patient behavior as *resistant* or *nonadherent.* The terms varied, but Sophia's statement, "You want to be as objective as possible, (pause) obviously this [medical record] is a legal document and you don't want to be terming anybody" represented the perspective of most. Isabella proposed, "There should be something to, you know, to identify these cases that are kind of intricate and in need of a better approach." Several HHC RNs described encounters in which their safety was directly compromised because of a failure in communication. When details were not documented in the patient referral, in the medical record, or at a minimum verbally communicated, such as unusual patient or caregiver behavior, others in the home, evidence of drug use, alcohol abuse, weapons not being secured, unsanitary living conditions, and psychiatric diagnoses, the HHC RNs felt they had entered unknowingly into a potentially unsafe environment.

Theme 2: Navigating the unknown

It is standard in HHC for the initial encounter between the HHC RN and patient or caregiver to occur by phone. This standard was corroborated by HHC RNs in this study. In general, HHC RNs contacted the patient or caregiver to introduce themselves, explain the purpose for the call, and provide a "window of time" for the home encounter. Most patients or caregivers had been informed by the referral source that the HHC RN would be calling, understood the purpose for the HHC RN to come, and were reported to be "happy" the HHC RN was coming, but others were overwhelmed or irritated with the calls, did not understand who was calling, and, in some cases, refused HHC services. Several HHC RNs perceived the phone encounter as an opportunity to ask how the patient was feeling, explain what the HHC RN would do in the home, identify patient or caregiver priorities, "build trust" by resolving immediate concerns over the phone, and explore who else would be in the home or lived in the home. Most HHC RNs asked whether a caregiver would be in the home purely to determine whether there would be a caregiver to teach a skill. Only a few HHC RNs deliberately inquired who would be home and lived in the home to minimize the unknown and identify potential threats to their safety. As Jackson, explained, the assessment starts with the phone call: "You listen to their voice, the way they talk . . . how they're receiving you, I think you're just intuitive and your radar is up."

The majority of HHC RNs reported preparation was "key" to knowing what the HHC RN was "heading into," "going to do," and, if needed, to being able to "pull back and make a better plan." Aubrey estimated she was aware of the situation in "probably 90% to 95%" of the cases, which was consistent with descriptions of other HHC RNs. However, the majority of HHC RNs stressed there was still a need to be prepared for cases that may

seem "benign." Isabella shared she learned to "trust [her] instincts ... it's been said to me by ... policemen [and others] ... if the hairs on the back of your neck go up, pay attention because I think in that situation I first described, there were subtle hints and I didn't pay attention." What was "unknown" to the HHC RN emerged as a dominant factor in encounters that posed a direct threat to the RN. See Table 2 for HHC RN-shared strategies to navigate the unknown.

Theme 3: Looking for reciprocality in the encounter

The complexity of nurse interactions became evident early in the interviews as HHC RNs shared how they tailor their approach to each patient, caregiver, and situation. Most encounters were described as "rewarding" even if initially the HHC RNs perceived resistance to their presence, intervention, gender, or ethnicity. In encounters in which the HHC RN felt they had developed a rapport or at a minimum connected with a patient or caregiver, someone in the home would offer to take their jacket, provide a seat or space to work, call the HHC RN by name, offer food or a beverage, thank the HHC RN, accept the HHC RN's apology if "running late," and be willing to reconcile issues that arose. Ella shared, "They're irritated and or exhausted ... they snap at you a little bit ... then they'll say you know I'm sorry. I'm just so tired I don't mean to take it out on you." In some situations, patients shared HHC RNs' concerns about their safety in their neighborhood. The HHC RNs recounted situations where family members and neighbors of patients met them on the street, directed them where to park, and "watched" their car while they were in a home.

In some homes the HHC RN did not want to set anything down. HHC RNs described homes with "tunnels with newspapers," homes in which "you could not move," and sometimes "places no one else would go." Isabella commented, "Strange situations you know ... squirrels, bed bugs, we just do it." Some HHC RNs took extra steps when caring for patients in these types of homes such as disinfecting shoes and avoiding offending a patient by carrying supplies in a "nice plastic bag" instead of a "garbage bag." As Sophia shared, "You're not afraid to shake someone's hand that might be dirty or smell or you know, that kind of thing, and I think people realize and pick up on that you are willing to, you know, be there for them." Jackson recalled knocking on a door of a home and the door "opened immediately." The home was too cluttered for Jackson to enter: "Everything that you could imagine ... with just a small path to wander through it ... I think she pulled up a chair or something and I basically sat in the doorway." The HHC RNs shared strategies to promote reciprocality and positive reciprocity (Table 3).

Table 2. HHC RN Strategies to Navigate the Unknown

Review the patient record for history of • acting out in hospital or signed out against medical advice • substance or alcohol abuse • psychiatric diagnosis like posttraumatic stress disorder • health condition caused or aggravated by trauma such as a gunshot • incarceration • evidence or suspicion of domestic abuse
Initial phone encounter • ask who else lives or will be in the home when the RN is present
Use of cellphones with global positioning systems

Abbreviations: HHC, home health care; RN, registered nurse.

Theme 4: Mitigating risk

Study participants reported significant changes in the HHC industry during the past 30 years. RNs who worked in HHC in the 1980s and 1990s described a competitive market. Organizational priorities were to "keep

Table 3. HHC RN Strategies to Promote Reciprocality and Positive Reciprocity

- Recognize patient or caregiver priorities
- "Build trust" by resolving immediate concerns
- Identify opportunities to demonstrate HHC RN is professional, has "clear value," and is competent
- Consistency in approach and HHC RN if possible
- Position self so as not to "stand over them"
- Assess for cues to proceed and "ask before do"
- Subsequent visits "go in with a forgiving mind"

Abbreviations: HHC, home health care; RN, registered nurse.

accounts happy" and provide "24/7 service no matter the time or location of the visit," often without police or security escorts. Aubrey reported it was the norm "not to say no to anybody and see patients anywhere." HHC RNs reported there were "not a lot of standards," "formal literature," "policies," or "procedures for inappropriate behaviors." More recently, most HHC RNs described being equipped by organizations with cell phones with global-positioning-system capability, attending in-depth training with law enforcement, and mandated security or police escort in areas with a high incidence of crime. Still, in this study, every HHC RN described at least 1 incident in which they had cause to be "scared" or reported hearing the stories of others who were scared. Amelia explained, "You never know what you're [going to] walk [into], what you're going to open that door and find." Several HHC RNs described only exposure to basic safety programs, content in academic programs, or no training at all. Mitigating risk emerged as a priority for HHC RN safety.

Several HHC RNs detected no issues with patients while on the phone yet encountered yelling and screaming in the home, deplorable conditions, animals, unsecured guns, overt illegal drug use, and gang activity. Liam shared, "You might get it right on the phone ... sometimes you may not." HHC RNs reported traveling to many homes in areas that were isolated or identified by organizations as "high risk" if there was an increased incidence of crime. Many HHC RNs described being "on guard" with patients or caregivers who were bigger in physical stature and judged to have the physical ability to harm the HHC RN. Those who had personally experienced an assault, a direct threat, or had received in-depth training related to potential violent encounters described being more alert to patient behavior, the presence of others, and anything unusual in the home environment than did those HHC RNs without that experience or training. Others stressed not underestimating female patients or caregivers, bedbound patients, and patients in wheelchairs. Liam described an encounter with a female caregiver: "She called us to come. Once we came in, she slammed the door ... she said if you stay here, I'm [going to] kill you! ... I had to call 9-1-1."

Overall, HHC RNs were prepared to respond to general personal questions but were careful to maintain professional boundaries and their privacy. Aubrey explained, "I used to share a lot more with them [patients] and then when you find out someone's a level-3 sex offender and you're thinking, crap! I didn't want to talk about my daughter." Organizations advocate to "keep the boundaries" but as 1 HHC RN disclosed, "It's really hard in home care because the professional line gets blurred." Several HHC RNs described organizations that had a supportive leadership, nonpunitive culture, and "zero tolerance" for inappropriate or abusive behavior. As Isabella explained, "If there are flags ... a patient that was very combative in the hospital—you know, yelling at the nurses—I'll bring that forward right away so that we know going in there could be an issue." In these organizations, cases are reviewed in advance to mitigate risk and ensure the necessary resources such as social workers and security

escorts are in place to support the HHC RN. Only a few HHC RNs described referencing the literature for guidance, but many shared strategies and recommendations to mitigate risk (Table 4).

Subtheme 4A: Pervasive anger and frustration

Anger and frustration were such dominant emotions that some degree of patient or caregiver anger and frustration were expected during initial or first-time encounters. Expressions of anger and frustration were common among patients who were very ill, debilitated, or had functional limitations. In 1 encounter, Chloe did not assess an angry patient to be a threat because he "didn't get in [her] face," raise his voice, was not "beyond verbal reasoning," and he listened. Chloe explained she would have perceived the patient as a threat if he continued to yell, showed no respect for her personal space, or became "physical" such as picking up or moving the medications away. However, Chloe felt the angry encounter would have been avoided had she been fully informed of the patient's psychiatric diagnosis and the recommended approach for his care. Several HHC RNs attributed angry encounters to being uninformed or missing a "trigger" such as simply opening "a curtain for light" or putting "up a shade" in a dark room.

Table 4. HHC RN Strategies and Recommendations to Mitigate Risk

Be attentive and scan environment • presence of others, such as gang activity • drug paraphernalia • unsecured weapons • unsanitary living conditions and odors • heavy-duty locks and chains on doors
Multidisciplinary case conferences that include opportunities for peer support
In-depth training with law enforcement
Mandatory security or police escort in high-risk areas
Organizational "zero tolerance" policies, processes, and positions "to filter" and to screen for a "red flag"
Topics for academic and continuing education • substance abuse • family dynamics • psychiatric diagnoses • domestic abuse • culture awareness • simply a better "way" to "talk to people" • training on potential triggers of angry and research-supported strategies to dissipate anger

Abbreviations: HHC, home health care; RN, registered nurse.

Overall, anger and profanity were not perceived as sufficient cause to end an encounter that was not going well. Key to the HHC RN assessment was, as Madelyn shared, "What are they yelling and screaming at or about?" Angry and frustrated patients or caregivers were perceived as "venting" if the HHC RN was not the target. However, situations in which patients or caregivers targeted or directed anger and profanity at the HHC RN were judged to be a threat. Amelia shared, "She was very, very, very angry . . . I didn't feel like I was in harm's way in any way, but I certainly kept my distance. Certainly stayed near her husband." Most HHC RNs had a heightened awareness of patients or caregivers who became angry or defensive with assessment questions, were not satisfied with explanations, reacted "unreasonably to change," or viewed the HHC RN as "taking something away." Ava commented, "I think it was what they [patient, family members, and neighbors] didn't do."

Body language that did not "soften" with HHC RN responsiveness, and expressions of empathy, was assessed as red-flag behavior by some. In these encounters, HHC RNs with less nursing experience "tried once and felt like [they] couldn't do much more." Other red-flag behaviors that HHC RNs found threatening were "clenched fists," "attack mode" position, standing when the HHC RN is sitting, leaving the room in anger, and "glaring" at the HHC RN. Angry patients or caregivers were described as "aggressive" if they

"physically moved into," "invaded," or did not "respect" the HHC RN's personal space. As Olivia described, "It's the people that get right there . . . someone who gets in my face."

Angry patients or caregivers who threw an object or "physically aggressed" toward the HHC RN crossed the "line." The "line" at which HHC RNs stopped trying to resolve or reconcile was getting "that feeling from the person, it's like, alright, we're done here." With more experience as an RN, the line for deciding to leave "shifted" and changed from "patient to patient." Most experienced HHC RNs reported attempting to "diffuse" an escalating encounter if they judged the individual could be reasoned with and a potential solution was within their skill set. However, more experienced HHC RNs also described encounters that ended with them being told to "get out" or being chased from the home. The 2 key descriptors that indicated an encounter was beyond reconciliation or diffusion were a patient or caregiver who resisted all potential solutions or were "not hearing what [the HHC RN was] saying."

HHC RNs who detected patient or caregiver anger during in-home encounters would "step back" to discern the underlying cause of the anger. Most in-home encounters were resolved with silence, listening, apologizing, or RN interventions. Being task focused, "distracted," "always running" from visit to visit, and giving "people the benefit of the doubt" were associated with missing a potential threat or cues an encounter was not going well. As Isabella commented, "We tamp down the radar in order to take care of people and I think that gets us into trouble."

Interconnecting theme: Acknowledging not all encounters go well

Encounters that did not go well were reported as "rare," but each HHC RN reported at least 2 such encounters in the home and several described phone encounters that did not go well. Initially, only 1 participant could not recall any encounters that did not go well, saying "they're all so wonderful," but, as the interview continued, she also shared incidents of patient anger, being yelled at, and being asked inappropriate personal questions. Despite variance in the HHC RNs' gender, ethnicity, age, years of RN experience, educational level, and geographic location of employment, similarities existed in encounters that did not go well. Some HHC RNs described patients or caregivers as "reluctantly accepting you" and "not really [being] receptive to [the HHC RN] being there." The 3 key descriptors of encounters that did not go well focused on (1) patient or caregiver anger or frustration, (2) lack of reciprocity, and (3) being unable or finding it "hard" for the HHC RN "to move [the patient or situation] forward."

Most of the HHC RNs relied on personal experience, "common sense," stories of others, and their "gut" to navigate encounters that did not go well. They communicated that if there was a "chance," they would try to "calm down" the patient or caregiver to dissipate the anger and move forward with the goals of the visit. They were candid and sensitive to the impact fatigue had on their ability to reconcile encounters that were not going well. As Emily explained, "I was tired . . . was not able to again back off and listen to where he was coming from." She further shared, "I think, I do best when I am able to really hear . . . where the person is coming from and . . . I don't do that well if I've already had 2 or 3 visits that are the same emotional level." Even patient encounters that went well and had positive outcomes were reported to be emotionally and physically demanding. Ella shared that there is "nothing worse than seeing someone in pain and everyone hates you in the room . . . You never can take it personally because . . . you know it's multifactorial."

Both male and female HHC RNs experienced encounters that did not go well. In addition, both reported incidents of physical assault and sexually inappropriate behavior. However, male HHC RNs reported being sent to homes only to learn afterward that others had refused. Male HHC RNs also provided more description of the environment, others present, and physically where they

were in the home. When asked questions to explore whether a male HHC RN was more guarded during an in-home encounter, Liam responded "You're a male nurse ... I'm not [going to] say that I'm not going to keep that within my radar." Liam described distancing himself to avoid "offending somebody" and because it "gives me a chance to protect myself from somebody being so close." Several HHC RNs reported leaving a home quickly, with only female HHC RNs describing their exit being blocked by a perpetrator. Emma stated that in some encounters "The patient, for their own reasons, [was unable] to walk down a path of a partnership for health, and so be it," but most participating HHC RNs frequently put themselves at risk trying to reconcile issues in encounters where there was zero reciprocity and the patient or caregiver was assessed as not listening. It emerged from the data that HHC RNs must be prepared and acknowledge that not all encounters will go well.

DISCUSSION

An important early finding was that the terms *difficult patient* and *difficult encounter* were not generally used by the participants. As in previous studies, the term *difficult* was perceived as vague[57] and judgmental.[15] One goal of this study was to propose an empirically informed definition of what constitutes a difficult encounter. Three types of encounters were identified from the descriptions of HHC RN interactions with patients and caregivers. A *constructive encounter* is when 2 or more human beings—the nurse on the one side, and the patient, caregiver, or both, on the other—interact to achieve a mutually agreed-upon outcome. A *nonconstructive encounter* is when 1 or more human beings obstruct efforts to achieve at least 1 positive outcome. A *destructive encounter* is when 1 or more human beings direct anger at or physically aggress toward another human being.

Travelbee proposed rapport as the goal of the original encounter and the final phase of the human-to-human relationship.[38] In this study, the majority of nurse-patient encounters were reported to go well but, contrary to the Travelbee model, rapport was not the outcome for every encounter. Several HHC RNs described incidents of anger and sexually inappropriate behavior by patients or caregivers that occurred during initial or subsequent encounters. One-time and brief encounters have been identified by nursing[27,28,58] and mental health[15] as being associated with encounters that do not go well. In this study, frustration and anger were frequently associated with initial or first-time encounters between the nurse and patient or caregiver that did not go well. The conclusion reached after a 2004 exploration of caring and uncaring nurse-patient encounters in a Swedish emergency department was that "nurses' behavior does not correspond to any of the theories that stress a relationship as a prerequisite for good nursing."[59(428)] In this study, at a minimum a "working relationship" or the slightest evidence of reciprocality was needed to achieve at least "a small goal."

Regulatory agencies such as the US Occupational Safety and Health Administration, the US Centers for Disease Control National Institute for Occupational Safety and Health, and The Joint Commission have created guidelines, standards, and recommendations on the topic of workplace violence and prevention.[43,60,61] Several states have passed legislation to "establish or increase penalties for assault of nurses," and some states have mandated employers to offer education on workplace violence.[62(paragraph 2)] Many health care organizations have been perceived as prioritizing patient satisfaction over employee safety.[4,63] At a minimum, it has been recommended that nurses should be taught to protect themselves if a patient encounter is perceived to be escalating toward a violent interaction.[1] Some HHC RNs in this study placed themselves at risk trying to reconcile issues in encounters even when there was zero reciprocity and the patient or caregiver was assessed as not listening. Zero tolerance policies were described as effective by some

HHC RNs, but others perceived "zero tolerance" as "more [of] a facility-driven term." In this study, HHC RNs who described supportive and nonpunitive cultures were more empowered to "bring it forward" and seek guidance with anticipated or actual nonconstructive nurse-patient encounters.

The data shared by this study's HHC RNs are consistent with previous research that has documented that nurses are subject to threats and exposure to violence.[3-7,30,39] They correspond with Grindlay et al's report[30] of no relationship between the characteristics of the nurse and perception of threat during home encounters with patients. The findings are also in line with the Street et al study,[64] which revealed negative reciprocity as being associated with encounters that do not go well; in this study, lack of or no reciprocity was described in nonconstructive and destructive encounters. Anger was the emotion most frequently exhibited by patients, caregivers, or both in non-constructive encounters and as the cue most HHC RNs recognized as an indication that the encounter might become nonconstructive. The intensity, trigger, and target of the anger were the markers HHC RNs used to judge the potential threat to their safety. This concurs with May and Grubbs,[4] who revealed an incidence of angry patient interactions more than a decade ago.

IMPLICATIONS FOR FUTURE NURSING RESEARCH

This study's results support future research to broaden the understanding of nonconstructive and destructive encounters with the goal of evaluating strategies HHC RNs can use to prevent, de-escalate, or terminate a destructive patient encounter safely. Efforts should be directed toward specifically identifying and exploring potential triggers of patient and caregiver anger. Developing programs with embedded mental health care workers along the continuum of care would increase opportunities for direct patient and caregiver access to expert psychosocial and emotional support.

LIMITATIONS

There were limitations to the study. The initial recruitment strategy may have been selective, but a secondary recruitment strategy broadened the potential pool of participants. The use of HHC RNs to assist with the recruitment of potential participants outside the workplace minimized potential breaches in confidentiality within the workplace. A purposive sample of 20 HHC RNs is not representative of all HHC RNs' experiences, but an effort was made to recruit a purposive sample that had maximum range in age, RN experience, gender, and ethnicity. Generalizability is also limited because of the geographic restriction on data collection. Despite these limitations, the strengths of this study include the diverse group of HHC RNs from several different home care organizations and the rich description of the experiences they shared.

CONCLUSIONS

HHC RNs voiced a preference for objective and nonjudgmental language to communicate outcomes of nurse-patient encounters. Three types of HHC RN-patient interactions emerged from the data, with constructive encounters the norm and nonconstructive or destructive encounters less frequent. Strategies to promote reciprocality are routinely employed during HHC RN-patient encounters, but HHC RNs who miss cues that a strategy is ineffective or failed may be at risk in the home. Study data also lend support to refine and further develop some concepts, assumptions, and propositions of Travelbee's human-to-human relationship model.[38] These study results provide a foundation for further research to increase the understanding, recognition, and development of empirically derived responses to nonconstructive or destructive encounters such that HHC RNs are safe and best able to meet patients' health care needs.

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