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## A Content Analysis of Patient Perception of Feeling Safe during Hospitalization

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### Abstract

**Background:** Patients are meticulous supervisors of their self-care. Their perceptions and experiences play a significant role in their awareness of the overt and covert problems in the healthcare settings. However, few studies have focused on the exact details of the nature of safety experienced only by the patients.

**Aim:** This study aimed to carry out the conventional content analysis of patients' feelings of safety during hospitalization.

**Method:** This qualitative study was conducted on a total of 31 patients hospitalized in various wards of hospitals affiliated to Shahid Beheshti University of Medical Sciences in Tehran, Iran, using purposive sampling in 2019. The data, obtained through semi-structured interviews, were analyzed by conventional content analysis using Graneheim and Lundman's approach (2004) with MAXQDA software (version 2010).

**Results:** Finally, data analysis resulted in the establishment of three main categories, namely feeling of insecurity, insolvency, and seeking safety and security.

**Implications for Practice:** The obtained results of the present study can be helpful in designing a patient-based care program focusing on patient safety. The healthcare team can improve patient care through the consideration of factors contributing to the feeling of safety in patients.

**Keywords:** Feeling safe, Hospitalization, Patients, Perception, Qualitative research

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## Introduction

The feeling of security and safety is one of the intrinsic human needs and is integrated with human nature. Since safety is one of the basic human needs, it seems that it exerts a considerable influence on the determination of the quality of life and satisfaction of individuals (1). According to Maslow's hierarchy of needs, the need for safety and security is one of the essential human requirements (2).

Safe care is a very fundamental principle in the perspectives of healthcare staff, managers, and policy-makers. It is a highly important issue in healthcare settings so that any shortage or deficiency in the provision of primary care is considered one of the major factors threatening patient safety (3). This threat will occur following the lack of perception of safety concept, ignorance about potential threats, and faults in the application of the technologies related to patient safety (4). According to the World Health Organization's definition of patient safety (2004), the reduction of unnecessary healthcare-induced damage to a minimum is acceptable.

Patients may be hurt by the healthcare causing iatrogenic permanent damage, increased hospital stay, and even mortality. In other words, patient safety means the prevention and decrease of untoward sequelae and adverse consequences (5). There are known and unknown factors in the subset of this need (2). Therefore, patient safety is considered a key indicator and element in securing quality healthcare, and this goal is multi-step, systemic, and multidisciplinary (6, 7). Consequently, nurses are regarded as the key members of the healthcare team because they form the largest group of care providers, and their basic role in care-giving and protection and promotion of the healthcare system is obvious (8).

The goal of patient safety is to provide safe care for the patient and personnel (9). Most studies on patient safety have been carried out in hospital settings since most of the safety events have been identified in hospitals. As a result, the need to perform patient safety studies is prioritized in hospitals and care-giving settings. However, the question should be answered whether patients really feel safe in the presence of these standards and studies conducted so far.

According to the evidence, it is indicated that patients are sensitive supervisors of their self-care, and their perceptions and experiences play an important role in their awareness of the overt and covert problems in the healthcare settings. Nonetheless, the exact details of the safety nature experienced only by patients have been addressed only in sporadic studies (10).

The concept of patient safety and associated effective factors have received less attention in previous studies as these studies have been mostly performed in a limited way in specialized care settings, such as intensive care units (ICUs), hemodialysis wards, and surgery wards (11-13). As a result, there is no comprehensive and full-fledged definition of the concept and available effective factors. Consequently, a content analysis of patient safety may provide a clear perception of the concept under study leading to the creation of standard care programs in the future. Therefore, the current study aimed to carry out the content analysis of patients' feelings of safety during hospitalization.

## Methods

In this study, conventional content analysis was used to describe a phenomenon and patients' emotional reactions to it. This approach is useful when the evidence or related theories are rare (14). The study settings included governmental hospitals affiliated to Shahid Beheshti University of Medical Sciences in Tehran, Iran. Conscious patients aged over 18 years hospitalized in in-patient wards of selected governmental hospitals for at least 3 days, able to speak in Persian and verbalize their perception, and inclined to participate in the study were selected using purposive sampling.

The patients' consent for participation was obtained, and the required data were collected by semi-structured interviews. The interviews were individually performed in a private silent environment in patients' convenience and recorded by a digital voice recorder. Firstly, some general opening questions were asked by the researcher to familiarize with the patients and create an intimate anxiety-free milieu. Then, more specialized questions directed toward the objective of the study were asked. The mean time of interviews individually performed was 45 min. The interview guiding questions developed by the research team were as follows:

What actions of the healthcare team give you the feelings of calmness and safety?

When do you feel exposed to dangers or risks during hospitalization?

Since your hospitalization, what factors disturbed your feelings of tranquility or safety?

What do you need to have greater feelings of calmness and safety in the hospital setting?

The interviews continued up to the achievement of data saturation. Finally, the interview was ended with some open questions. In addition to voice recording, the researcher took some paper-and-pencil notes related to verbal or non-verbal responses of the participants. To increase patient variety, the subjects were selected from different wards.

Data analysis was simultaneously conducted with data collection. In this process, the data were divided into the smallest meaning units. The new data were compared together in terms of similarities and differences and categorized through frequent reviews and integration of similar data. The obtained data were assessed by conventional content analysis using Graneheim and Lundman's approach (2004) (15). The data were analyzed qualitatively in the five steps, including 1) transcribing the whole interview immediately after completion, 2) reading the whole text to arrive at a general understanding/gist of the content, 3) determining the meaning units and primary codes, 4) categorizing the similar primary codes into more comprehensive categories, and 5) determining the main theme of the categories.

In this method, called the deductive model, the researchers avoid using the present categories and allow the categories and their labels to emerge from the data. At the end of the interviews, the recorded data were carefully listened to in no time and transcribed verbatim. Subsequently, the interview transcriptions were studied several times for the production of a general new idea through immersing in the data. Indeed, the data were collected through interviews and analyzed by semantic associations, and finally the main themes emerged. Reduction, merging, logical combination of the data, and abstraction were used in all phases of data analysis.

Validity, reliability, and objectivity are the criteria for quality assessment in qualitative studies (16). In the present study, data accuracy was established on the basis of five criteria, namely credibility, transferability, confirmability, dependability, and authenticity. The current study also used five Lincoln and Guba criteria (17, 18). In order to carry out the present study, the permission was obtained from Shahid Beheshti University of Medical Sciences with the ethics code of 1397.1129.

## Results

A total of 31 patients with a mean age of 43 years (range: 19-71 years) participated in this study. To ensure maximal patient variety, the participants were selected from different wards, including ICU, coronary care unit, surgery, internal, oncology, nephrology and transplant, obstetrics and gynecology, labor, urology, dermatology, and gastroenterology (Table 1). Data analysis resulted in 650 open codes categorized into three main categories, ten *Categories*, and five subcategories. The main categories included feelings of insecurity, insolvency, and seeking safety and security (Table 2).

### 1. Feeling of insecurity

This category consists of the two subcategories, namely feeling of anxiety and feeling unprotected,

**Table 1. Characteristics of patients participated in interview (n=31)**

Characteristic	n
Gender	
Female	15
Male	16
Age (year)	
Mean $\pm$ standard deviation (range)	43.0 $\pm$ 14.0 (19-71)
Hospitalization (day)	
Mean $\pm$ standard deviation (range)	9 $\pm$ 4 (4-21)
Educational status	
Primary	4
Diploma	8
Associate	2
Bachelor	10
Master	5
PhD	2

**Table 2. Indicators associated with the concept of feeling safe**

Quotation	Code	Subcategory	Category	Main category
<i>"Now, I see nightmares of cancer. I was always afraid of cancer as my grandpa and grandma both died of cancer. My mind is filled with the belief that all cancer patients will die". (Patient 28)</i>	Painful procedure, relatives' mortalities due to a similar disease, unsuccessful surgery, and disrespect for the patient fear of cesarean section (CS) due to watching other mothers with CS	Patient's previous negative experiences		
<i>"Nurses administer my medications incompletely; for example, they discontinued my previous medications and started new drugs; yet, when I object to them, they give me my previous medicines again. They said: "we don't know"; however, I had told them that the doctor had told me to discontinue rituximab. When I remind them of it, they simply said that the residents have prescribed it and I should take it. I don't really know what to do, whether take it or not, or for example, I should take a 1-g dose of one of my medications; yet, they brought a 250-mg dose; then, I had to stay up, go there, and tell them that they gave me the wrong dose. Nurses either don't read the chart or read it wrongly". (Patient 6)</i>	Treatment team, physician's knowledge, and students' competency	Lack of confidence in the treatment team	Feeling of anxiety	
<i>"Pensions are very low, and hospital costs are high for me. The government must support us. One of my concerns is the cost of my treatment during discharge." (Patient 10)</i>	Purchase of medical materials and instruments, costs of attendants, and costs of a hospital bed	Financial challenges		Feeling of insecurity
<i>"The air conditioner does not work at all. The bathroom smells bad". (Patient 8)</i> <i>"The emergency ward and clinic are overcrowded. It's because this is a governmental center with good facilities and equipment. All patients want to come here; then, the staff is exhausted, gets angry at patients, and misbehaves them. Since there are a few nurses here, patients go mad. These tensions give the patients a feeling of discomfort". (Patient 11)</i>	Inappropriate working conditions, dissatisfaction with rules and regulations, inappropriate nutritional conditions, lack of sexual correspondence between patients and staff, shortage of facilities and equipment, inappropriate hospital structure, inappropriate hospital sanitation, inappropriate room temperature, and crowd of students at the bedside	Environmental annoying factors		Feeling unprotected
<i>"There is no coordination among them here; for example, the doctor told me that I should be hospitalized for operation on Monday. When I presented to the ward, the students told me that the surgery list was full on Monday and asked me to go and come back next week". (Patient 30)</i> <i>"I have to be hospitalized for a few days to have an endoscopy. Then, when I went to the endoscopy department with a nurse a few days later, I had to wait a long time for my turn". (Patient 19)</i>	Long waiting time, disturbance during patient's sleep, lack of coordination among the treatment team, insufficient attention to the patients and their attendants, medical errors during care-giving, and insufficient commitment of the treatment staff	Reception of ineffective care		



**Table 2 Continued.**

<p><i>"I have completely lost hope, feel like I am an extra person, and have caused a lot of trouble for my family. I thought about suicide many times". (Patient 3)</i></p>	<p>Feeling of gradually fading away, feeling of being a load on others' shoulders, suicide thoughts, and in limbo between life and death</p>	<p>Loss of hope</p>	
<p><i>"Since last year, I have been hospitalized several times due to my problem, and I have spent time hoping that I will finally recover. I'm really tired". (Patient 17)</i></p>	<p>Fatigue experienced following repeated history takings by residents, repeated hospitalizations, frequent surgical complications, patient's wandering about, annoyance due to lack of skillfulness of the staff in care-giving, and patient's insolvency due to numerous treatments</p>	<p>Mental exhaustion</p>	<p>Insolvency</p>
<p><i>"Doctors look at us as a customer and not humanely. When I'm going to have surgery or treatment, they don't justify me at all. Doctors are only thinking about money". (Patient 15)</i></p>	<p>Feeling of being abandoned/secluded, being overlooked lack of a humanistic approach toward the patient, and lack of justification for the treatment course</p>	<p>Mental failure</p>	
<p><i>"I feel like I'm trapped in a cage. I'm not even allowed to leave the department. For me, every day is equal to a year". (Patient 11)</i></p>	<p>Disorganized functional duties of family members, feeling of being trapped in the ward, and discouraging the patient from the treatment course</p>	<p>Slow passage of the rough time of hospital stay</p>	
<p><i>"I asked my nurse several times to come to my bedside, but she didn't pay attention to me, and I had to shout and show my anger so that she would pay attention". (Patient 1).</i></p>	<p>Asking the treatment team to attend their bedside and getting angry resulting in complaining to the office</p>	<p>Efforts to be seen</p>	<p>Seeking safety and security</p>
<p><i>"When doctors and nurses didn't explain to me about illness and treatment, I searched the net to find out what they were doing. Sometimes I listened carefully to what they were saying about the disease". (Patient 2)</i></p>	<p>Listening to physicians during their ward rounds, listening to nurses during their shift change, regular controlling of the drugs, seeking information on the internet, making efforts for contributing to the treatment course, and requesting for providing information on the part of the treatment team</p>	<p>Attempts for awareness</p>	
<p><i>"When I found out that the doctor had prescribed painkillers for me, while I was not in pain, I had to secretly throw away the drugs and pretend that I had taken my medicine". (Patient 21)</i> <i>"I have been living in this atmosphere for some days. I'm mentally tired; yet, they don't allow me to go out. I concluded that I must leave the ward secretly without their permission or awareness." (Patient 1)</i></p>	<p>Disposing of medications secretly, leaving the ward secretly, showing pretentious good behavior toward nurses, hiding precious properties, and paying money for fulfilling their duties</p>	<p>Pretention and concealment</p>	
<p><i>"To forget the discomfort and reduce my stress, I tried to calm myself down by praying. Sometimes I read a book". (Patient 23)</i></p>	<p>Walking, reading books, lying or sleeping, talking to the family, playing, watching TV, and praying</p>	<p>Challenge for internal turbulence</p>	

indicating the perceived internal and external risks and dangers. In other words, when individuals see their soul and body at risk, they experience feelings of unsafety (Table 2).

*1.1. Feeling of anxiety:* The presence of certain factors in the patient's environment causes a lot of stress and anxiety. This subcategory consists of patient's previous negative experiences, lack of confidence in the treatment team, and stressors.

*1.1.1. Patient's previous negative experiences:* These experiences that have played a negative role in the patient's feelings of insecurity include the experience of a painful procedure, relatives' mortalities due to a similar disease, unsuccessful surgery, disrespect for the patient, and fear of cesarean section (CS) due to watching other mothers with CS.

*"Now, I see nightmares of cancer. I was always afraid of cancer as my grandpa and grandma both died of cancer. My mind is filled with the belief that all cancer patients will die".* (Patient 28)

*1.1.2. Lack of confidence in the treatment team:* A lack of patient's confidence in various individuals, such as the treatment team, physician's knowledge, and students' competency would lead to the lack of patient's confidence in the whole healthcare system.

*"Nurses administer my medications incompletely; for example, they discontinued my previous medications and started new drugs; yet, when I object to them, they give me my previous medicines again. They said: "we don't know"; however, I had told them that the doctor had told me to discontinue rituximab. When I remind them of it, they simply said that the residents have prescribed it and I should take it. I don't really know what to do, whether take it or not, or for example, I should take a 1-g dose of one of my medications; yet, they brought a 250-mg dose; then, I had to stay up, go there, and tell them that they gave me the wrong dose. Nurses either don't read the chart or read it wrongly".* (Patient 6)

*1.2. Feeling unprotected:* This subcategory consists of financial challenges, environmental annoying factors, and reception of ineffective care.

*1.2.1. Financial challenges:* These are caused by the patient's financial problems at the hospital due to the costs of dressings, purchase of medical materials and instruments more than required, costs of attendants, and costs of a hospital bed. These factors resulted in the patient being in need of support.

*1.2.2. Environmental annoying factors:* Some factors in the immediate surroundings of the patient during hospitalization, such as nurses' inappropriate working conditions, dissatisfaction with rules and regulations, lack of sexual correspondence between patients and staff, shortage of facilities and equipment, inappropriate hospital structure, inappropriate hospital sanitation, inappropriate room temperature, and crowd of students at the bedside, are disturbing for the patient.

*"The air conditioner does not work at all. The bathroom smells bad".* (Patient 8)

*1.2.2.1. Nurse's inappropriate working conditions:* Working conditions cover the areas, such as space, temperature, lighting, ventilation, humidity, and welfare facilities. Sometimes the staff is not motivated enough to be satisfied with the job, and in many cases they get tired, all of which can be understood by patients. This refers to personnel's work overload, insufficient number of staff, attendant's irrational expectations, nurse bothering by attendants, crowded hospitals, patients' overload, nurse's exhaustion due to work overload, and nurse's insufficient income. One of the patients complained as follows:

*"The emergency ward and clinic are overcrowded. It's because this is a governmental center with good facilities and equipment. All patients want to come here; then, the staff is exhausted, gets angry at patients, and misbehaves them. Since there are a few nurses here, patients go mad. These tensions give the patients feelings of discomfort".* (Patient 11)

*1.2.2.2. Dissatisfaction with rules and regulations:* Some hospital rules are disturbing for patients, such as long close vigilance in the emergency room, insufficient security of patients' precious things against thieves, lack of permission for attendant presence at the bedside, lack of control of visitors' exit and entry, lack of permission for patients to exit the ward, lack of permission for husband's attendance on the bedside in gynecology and obstetrics wards, and insufficient attention to patient's rights.

*1.2.2.3. Inappropriate nutritional conditions:* This refers to the low quality of foods, low variety in food items and menu, and lack of attention to the patient's nutritional diet.

*"I have diabetes, but my food is not suitable for a diabetic patient at all. For example, lunch is rice every day, and they bring honey for breakfast. They don't care at all!"* (Patient 15)

1.2.2.4. *Lack of sexual correspondence between patients and staff*: The open codes of this category were the presence of male staff in the gynecology ward and lack of the separation of males from females". In this regard, another patient said:

*"All the nurses here are gentle and noble. When I had no attendant, I was ashamed to ask them to empty my Foley catheter; I had to go to the toilet myself and empty it"*. (Patient 5)

1.2.2.5. *Shortage of facilities and equipment*: This can be highly annoying for the patient. The open codes of this subcategory were the provision of medical materials and appliances out of the hospital, inappropriate condition of emergency room, out-of-order bed alarm, lack of uniformity of patients' hospital uniforms, lack of the right-size uniform, provision of primary facilities out of the hospital, patient annoyance due to repeated transportation by ambulance, shortage of sufficient medical equipment, lack of sufficient medical supplies, and shortage of disposable materials and instruments.

1.2.2.6. *Inappropriate hospital structure*: This refers to a lack of separate toilets and bathrooms, no parking lot, insufficient number of sanitary toilet services, unsuitable architecture of the ward, unpleasant feeling of the patient due to sheet color, and inappropriate room temperature.

1.2.2.7. *Inappropriate environmental sanitation*: Improper sanitation is annoying for patients, and the pollution entails many parts of the treatment setting. Improper sanitation includes the inappropriate sanitation of the ward and hospital settings, unsuitable cleaning of the ward, out-of-order toilets, noise pollution in the ward, and annoyance in the ICU due to the foul odor of the unconscious patients.

1.2.2.8. *Crowd of students on the bedside*: This refers to holding educational and training classes at the bedside and students' and clinicians' long conversations at the bedside.

1.2.3. *Reception of ineffective care*: This includes patient's long waiting time, disturbance during patient's sleep, lack of coordination among the treatment team, insufficient attention to the patients and their attendants, medical errors during care-giving, and insufficient commitment of the treatment staff.

1.2.3.1. *Patient's long waiting time*: This consists of long waiting times for diagnostic procedures, discharge, hospital admission, clinic admission, and surgery in the recovery room.

1.2.3.2. *Disturbance during patient's sleep*: Some factors impair patient's rest and sleep, such as conducting nocturnal diagnostic procedures, performing invasive procedures on asleep patients, visiting the patient at inappropriate times, cleaning the ward at unsuitable times, blood sampling at inappropriate hours, and drug administrating at unsuitable hours.

1.2.3.3. *Lack of coordination among the treatment team*: This indicates contradictions between a physician's order with a nurse's speech, delayed surgery, and insufficient supervision. One patient betrayed it as follows:

*"There is no coordination among them here; for example, the doctor told me that I should be hospitalized for operation on Monday. When I presented to the ward, the students told me that the surgery list was full on Monday and asked me to go and come back next week"*. (Patient 30)

1.2.3.4. *Giving insufficient attention to patient and attendants*: This refers to a lack of attention to the needs of patients and attendants, sending patients' attendants out while visiting them, ignoring patient's and attendant's requests, lack of patients' and attendants' contribution to the treatment course, lack of patient follow-up after diagnostic procedures, considering the attendants responsible for the patient care, lack of personnel's attention to patient's warning signs, lack of explanation of new procedures to the patient, inattention to patient's primary needs, lack of humanistic approach toward the patient, devaluing the patient, lack of patient justification during treatment, treatment team's inattention to patient costs, and low importance of patient's treatment for the treatment staff.

1.2.3.5. *Medical errors during care-giving*: These include delay in treatment, delay in diagnosis, lack of recording real vital signs, errors in diagnostic procedures, pharmacological (medicinal) errors, repeated wrong diagnostic procedures, and wrong identification of the patient.

1.2.3.6. *Insufficient commitment of the treatment staff*: This refers to inappropriate behaviors of the treatment staff, treatment team's not introducing themselves to the patient, medical student's misbehavior toward patients, making fun of and poking fun at patients, personnel's aggression toward each other, insulting the patient, inappropriate rapport with the patient, inattention to physical and mental care-giving needs, treatment team's dishonesty, lack of explanation of the treatment course, lack of nurse's awareness of the treatment course, nurse's thoughtless compliance with the physician, lack of providing education for the patient, delay in drug administration, lack of correct performance



of duties, and lack of follow-up of patient's treatment course.

## **2. Insolvency**

When patients do not feel safe and their efforts fail, they feel insolvency. This category consists of four subcategories, namely loss of hope, mental exhaustion, mental failure, and slow passage of the rough time of hospital stay.

*2.1. Loss of hope:* This includes the open codes of the feeling of gradually fading away, feeling of regarding him/herself as a load on others' shoulders, suicide thoughts, and in limbo between life and death.

*2.2. Mental exhaustion:* This refers to the fatigue experienced following repeated history takings by residents, repeated hospitalizations, frequent surgical complications, patient's wandering about, annoyance due to a lack of skillfulness of the staff in care-giving, and patient insolvency due to numerous treatments.

*2.3. Mental failure:* It occurs after the feeling of insolvency, feeling of being abandoned/secluded, feeling of being overlooked, lack of a humanistic approach toward the patient, lack of justification for the treatment course, and inappropriate behavior of the treatment staff.

*2.4. Slow passage of the rough time of hospital stay:* This occurs following the disorganized functional duties of family members, feeling of being trapped in the ward, and discouraging the patient from the treatment course.

## **3. Seeking safety and security**

This category refers to the efforts made and measures taken to remove the feelings of unsafety and insecurity. It consists of four subcategories, namely the efforts to be seen, attempts for awareness, pretention and concealment, and challenge for the internal turbulence.

*3.1. Efforts to be seen:* The patient asks the treatment team to attend their bedside, then gets angry, and finally complains to the office.

*3.2. Attempts for awareness:* To become aware, the patient performs actions, such as listening to physicians during their ward rounds, listening to nurses during their shift change, regular controlling of drugs, seeking information on the internet, making efforts for contribution to the treatment course, and asking for information on the part of the treatment team.

*3.3. Pretention and concealment:* Sometimes, the patient has to conceal some issues or pretend that they are doing something; for instance, disposing of medications secretly, leaving the ward secretly, showing pretentious good behavior toward nurses, hiding precious properties, and paying money for fulfilling their duties. For example:

*"I have been living in this atmosphere for some days. I'm mentally tired; yet, they don't allow me to go out. I concluded that I must leave the ward secretly without their permission or awareness".* (Patient 1)

*3.4. Challenge for the internal turbulence:* This refers to compatibility mechanisms applied by the patient to adapt to new conditions or tolerate inappropriate conditions, such as walking, reading books, lying or sleeping, talking to the family, playing, watching TV, and praying. They even ask continually the patients with similar surgeries to overcome the stress induced by surgical operation and become tranquilized by the successful result of their surgery.

## **Discussion**

The obtained results of the current study showed that hospitalized patients need to be provided with safety and security. When patients face some problems and feel unsafe, they try to control their affairs through security-seeking measures (seeking safety and security). If their attempts are futile, they will feel unsafe and insolvent. However, if their efforts are fruitful or they do not face any deficiency or shortage since the beginning, they will experience hopefulness about the treatment, confidence in the healthcare team, and safety.

Reception of ineffective care was one of the important subcategories investigated in many studies (3, 19). Most scholars have highlighted the importance of the presence of the personnel and their communication with patients (12, 20-25). Communication is one of the important and necessary factors in information transmission, support, and care. All these factors will not be effective without the presence of the staff at the patient bedside (20). Among the healthcare staff, nurses play the most significant role in creating feelings of safety and security (12).

From the patient's perspective, nurses should be knowledgeable, aware, inventive, intelligent, up-to-date, and skillful individuals to be able to provide effective, efficient, and efficacious care for patients (20, 26-29). Safe care per se will not create feelings of safety and security in patients; however, this feeling goes somehow beyond the physical needs and gains a mental dimension (12, 22) in order to maintain and always respect patients' dignity and self-esteem (11, 26, 28).

According to the literature, it was demonstrated that an appropriate environment and suitable technology are influential factors in creating the feelings of safety and security; accordingly, an appropriate environment possesses good structural conditions (e.g., temperature, lighting, and humidity) (3, 30), and with technology we mean the presence of sufficient and up-to-date therapeutic facilities and equipment in the healthcare system (22). Based on the studies conducted to date, technology has been considered an entity separate from patient settings. Technology and patient settings have been presented as two separate categories.

The seeking safety and security category was one of the important distilled categories in the present study indicating how patients seek to create safe conditions after the observation of an inappropriate situation. This condition that is out of their expectations makes them challenge for changing or even coping with it. Indeed, this measure taken by the patient is an effort to compensate for their perceived ignorance (31).

Insolvency as another category obtained from the results of the present study indicates how patients find themselves forgotten and insecure due to the lack of a sense of safety. Sometimes, in that situation, they resort to spirituality (13), and if they cannot change the situation or adapt to it, they feel insolvent and this feeling will be manifested variously as loss of hope, mental fatigue, mental failure, and slow passage of the tough time during the hospital stay.

One of the important theories very close to creating a feeling of safety in patients is Kolcaba's comfort theory. According to Kolcaba's theory, the need for comfort is created in stressful healthcare situations in which the patient cannot naturally fulfill it. These needs may be physical, psychological, sociocultural, or environmental assessed through supervision, verbal reports, informal reports, pathophysiological parameters, education and support, consultation, and intervention (32, 33).

The obtained findings of the current study suggested that patient's perceived feelings of safety and security are affected by various factors, such as healthcare team performance and environment. One of the limitations of this study is the sampling of public hospitals only and no inclusion of private hospitals.

### **Implications for Practice**

The results of the present study can be helpful in designing a patient-based care program with a focus on patient safety. The healthcare team can improve patient care by considering factors that produce a feeling of safety in patients.

Based on the results of the present study, it is suggested that by the development of patient-based care programs, the effect of using these programs on the patient's sense of safety should be measured. In addition, it is recommended to carry out future studies focusing on the development and psychometric validation of instruments for measuring inpatients' perceived feeling of safety to obtain a more accurate estimate of this variable.

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### **Conflicts of Interest**

The authors declare that there is no conflict of interest.

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