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ORIGINAL RESEARCH

Healthcare Personnel Experiences With Health Literacy Sensitivity in Relation to Work Satisfaction and Stress: A Qualitative Study

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Objective: To qualitatively explore healthcare personnel's (HCP) experiences with health literacy sensitivity in relation to work satisfaction and stress. Being HL sensitive means that HCP have adequate knowledge, skills, and attitudes to follow up on patients' HL needs.

Methods: Four focus group interviews were conducted with 30 hCP from a medium-sized general hospital in Oslo, Norway. We used inductive thematic analysis developed by Braun & Clark. NVivo v12 software assisted data analysis.

Results: Three main themes were identified: (1) HCP experiences with HL (2) HCP experience barriers with HL sensitivity, and (3) HCP collaboration and communication are essential for HL. Variability in HL understanding among HCP may lead to challenges in providing patient-centered care. Factors such as heavy workloads, cultural barriers, and organizational limitations hinder HL sensitivity and can cause frustration and stress among HCP.

Conclusion: Targeted interventions and organizational support are essential to address HCP's obstacles with HL sensitivity. Utilizing improved communication techniques and HL tools may help reduce stress and frustration.

Practice Implications: To optimize HL sensitivity, it is imperative to prioritize HCP needs. Organizations should strive to facilitate HL in a way that does not impose additional stress on HCP.

Keywords: health literacy, health literacy sensitivity, health literacy responsiveness, hospital, work satisfaction, work stress

Introduction

The World Health Organization defines health literacy (HL) as the ability to "gain access to, understand and use information in ways which promote and maintain good health"[1] for themselves, their families, and their communities.[2] The definition pertains to individual HL, but healthcare personnel (HCP) must also possess HL sensitivity, which means they have the necessary knowledge, skills, and attitudes to address patients' HL needs.[3,4] Health organizations are responsible for meeting patients' and the community's HL needs and preferences,[5] and their ability to do so is known as health literacy responsiveness (HLR). HL-responsive organizations aim to reduce complexity in healthcare and make it easier for people to navigate, understand, and use information and services to care for their health. HCP plays a key role in health organizations' HLR, and HCP experiences of stress, heavy workloads, and inadequate organizational leadership can negatively impact HL sensitivity.[6–8] Not surprisingly, patients struggling with HL bear the greatest burden of HCP inadequate HL sensitivity, which is particularly unfortunate given that these patients are already at increased risk of poor health outcomes.[4,9,10]

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A global effort to strengthen citizens' HL through better-designed healthcare systems is ongoing.[8,11] To achieve this goal, it has been pointed out that HCP need to be trained in HL competencies and skills.[3,12–14] Two decades have passed since it was first recommended that HCP receive training in effective communication with patients with HL challenges.[15] However, little seems to have changed, and HCP often overestimate their own HL knowledge and lack understanding of HL's importance, causing additional difficulties for patients.[16,17] Following up on patients' HL needs can become an added burden for HCP, giving them a feeling of responsibility for patients' actions.[18] Hence, there must be an alignment between patients, HCP, and the health organization when providing information, and patients must feel supported when striving to improve their HL.[16,19]

Healthcare organizations should provide HCP with resources to minimize the gap between patients' HL abilities and the demands and complexities of the healthcare systems.[20,21] HL sensitivity can improve patients' health outcomes and increase their satisfaction with HCP.[22] To accomplish this, HCP need recognition and support for their HL efforts. HCP working in direct patient care depend on the organization's willingness to support patients and HCPs' HL needs.[21,23] However, researchshows that HCP often lack support from management when they want to participate in HL training programs, as managers consider them costly and time-consuming.[21,24]

Even though HCP often work within highly stressful environments,[25] patient-centered care, and time spent with patients and their kin are generally experienced as a source of work satisfaction for HCP.[26] HCP who frequently work in stressful environments can experience reduced physical and mental well-being and burnout, affecting their capacity to care for others.[6,27] This may lead HCP to emotionally disengage from their work and carry out responsibilities in a way that conserves their energy, resulting in depersonalized care.[7] The job demands of HL sensitivity might be experienced as overly burdensome for HCP, but not all job demands are inherently unfavorable. However, it is important to recognize that job demands can easily become job stressors when meeting these demands requires great effort.[28] Frequently, exposure to job stressors, such as heavy workloads, can negatively impact HCP's mental and physical well-being.[27,29] By 2030, there will be a global shortage of 10 million HCP, resulting in additional workloads for those remaining in healthcare positions.[30] This poses a challenge to HL sensitivity, given that HCP experiencing stress and dissatisfaction can also affect the organization's overall well-being. This can manifest through increased HCP turnover and reduced patient satisfaction and safety.[26,27]

Although HL sensitivity has been explored in qualitative research,[10,16–18,21,23] to our knowledge, no other study has included work satisfaction and stress. This study aims to qualitatively explore HCP experiences with HL sensitivity in relation to work satisfaction and stress. Broadening our understanding in this area may improve HL sensitivity and work satisfaction for HCP.

Material and Methods

Study Design

In this exploratory-descriptive qualitative study, we conducted four focus group interviews with 30 hospital HCP from a medium-sized general hospital in Oslo, Norway. An exploratory-descriptive qualitative approach is valuable for summarizing, understanding, and investigating aspects of healthcare practices that have not yet been explored.[31] This design was chosen because it is suitable for exploring participants' experiences; furthermore, focus groups create space for discussions between multiple participants and benefit from group dynamics.[32,33] The study was reported according to the consolidated criteria for reporting qualitative research (COREQ) checklist (except for returning transcripts to the participants).[34]

This independent study is a satellite of the Magnet4Europe project, which aims to improve mental health and well-being in the healthcare workplace. A detailed outline of Magnet4Europe is available elsewhere.[35]

Sample and Recruitment

Maximum variation sampling was used to purposefully select participants with a wide range of experience in areas of interest and with different work responsibilities.[36] This included interdisciplinary healthcare professionals from all hospital departments, representing both genders and various levels of seniority. This sampling method was chosen to

enable participants to provide rich data regarding their experiences with HL sensitivity, work satisfaction, and stress in a hospital context. HCP in this hospital have no formal HL training, and systems have not yet been established to support HL initiatives. Eligibility criteria included employment as an HCP with a bachelor's degree or higher, working in direct patient care or management. HCP were recruited from all available hospital departments: medical, surgical, mental health and addiction, and administration. Information about participating in the study was communicated to employees in the target group through direct emails from the researchers or hospital management. Additionally, researchers conducted in-person recruitment by informing eligible employees during department meetings.

Ethical Considerations

The study was conducted in accordance with the Helsinki Declaration and approved by both the Regional Committees for Medical and Health Research (REK, protocol 166980) and the hospital's data protection officials for research. Before starting the interviews, participants received verbal and written information about the study. Participants were asked not to share information discussed in the group with anyone outside the group, and we emphasized that their participation was voluntary and that they could withdraw anytime. Written consent was obtained upon entry; participants were informed that their consent included publication of anonymized responses and direct quotes.

Data Collection

Focus groups were conducted in the hospital's administration building and lasted an average of 90 minutes. A semi-structured interview guide consisting of six open-ended questions regarding HL, workload, and well-being. The interview guide was inspired by three domains from the Organizational Health Literacy Responsiveness (Org-HLR) Self-Assessment Tool: (1) leadership and culture, (2) system, processes, and policies; (3) workforce.[5] HCP who agreed to participate in the interviews were placed into one of four focus groups, each with six to eight participants. This group size allows the moderator to effectively manage the discussion and ensure that all participants had the opportunity to share their insights and observations.[37] Interdisciplinary HCP from all departments ensured rich group dynamics and created an opportunity to understand participants' experiences across hospital departments. The focus groups were conducted in November 2022, with no follow-up interviews. Before starting the interviews, all participants answered a brief questionnaire about their socio-demographic characteristics and working arrangements.

At the beginning of each focus group interview, the participants and interviewers were introduced to each other, and then the main interviewer reviewed the research aim and reasons for doing this research. One female researcher moderated the focus groups (i.e, MNS, RN, CNM, PhD -student), and two female researchers (i.e, co-authors CRB and MHL, RN, PhD) were observers in two focus groups each. All researchers have experience conducting qualitative interviews. The observers took notes, observed the atmosphere, and contributed with follow-up questions. The interviews were audio-recorded and transcribed verbatim by MNS. The number of focus groups required was not determined before initiating the focus group interviews. Following the completion of four focus group interviews, the interviewers deliberated on the adequacy of information power, ultimately deeming it satisfactory, as no new information surfaced.[32] Consequently, recruitment and data collection were halted.

Data Analysis

Inductive thematic analysis was chosen to explore HCP's experiences with HL through the focus groups. The six-phase guide to thematic analysis developed by Braun and Clarke's was used,[32] and Table 1 describes how the six analysis phases were applied to this study.

Two researchers read the transcribed material, searching for meanings and patterns. The storage and retrieval software NVivo v12 was used for data management to assist with data analysis, and initial codes and themes were developed.[38] Four researchers experienced in qualitative methods held group meetings to discuss patterns and themes, addressing disagreements regarding themes and subthemes through open discussions. The study's methodological rigor was strengthened by experienced researchers' involvement in data analysis. Clarity and completeness were debated before the overarching themes were identified. Themes were written using key quotes to support the data.

Table 1 The Six-Phase Guide of Thematic Analysis Inspired by Braun and Clarke

Phase:	Description of Implementation:
1. Familiarizing oneself with the dataset	• An inductive approach was used. MNS and CRB read the transcribed interviews and made notes and mind maps of interesting items and initial codes. This phase had no limitations, but the study aim was kept in mind as reflections started.
1. Coding	• A list of initial codes from Phase 1 constituted the first codebook. • With the help of NVivo software, MNS & CRB individually coded the first interview. Together, they discussed recurring patterns in the dataset and revised the initial codebook. • The three other interviews were coded using the revised codebook. • MNS, MHL & CRB discussed the codebook and agreed on 23 included codes. • All interviews were coded a second time by MNS, but no new codes were included.
1. Generating initial themes	• Codes were discussed and sorted into 4 initial themes.
1. Developing and reviewing the themes	• A thematic map was made to evaluate the themes, ensuring that each theme had its own focus and limitations and was not overlapping. • Total of three overreaching themes were identified.
1. Refining, defining, and naming the themes	• MNS, CRB, MHL, and AKW discussed patterns and themes to ensure that the themes captured the primary content. • Clarity and completeness were debated before the overreaching themes were finalized and named. • Themes were written using key quotes to support the data. Participants did not get the opportunity to provide feedback on the findings.
1. Producing the report	• Findings related to the study aim were reported, supported by key quotes.

Results

Table 2 describes the 30 participants (23 females, 7 males) from four departments (ie, medicine, surgery, mental health and addiction, and administration). The average age of the participants was 44 years (range: 23–68 years), while the average length of experience working in the hospital was nine years (range: 0–25 years). The majority (63%) worked in direct patient care, while 37% worked in administration or had a special function.

Figure 1 demonstrates the results of the analysis's main themes and sub-themes. The analysis process identified three main themes: (1) HCP experience with HL, (2) HCP experience barriers with HL sensitivity, and (3) HCP collaboration

Table 2 Participant Socio-Demographic Characteristics and Working Conditions (N = 30)

Characteristic	Statistics
Age in years: Mean (SD) Min-Max	 44.1 (13.6) 23–68
Sex, n (%): Male Female	 7 (23%) 23 (77%)
Department, n (%): Medical Surgical Mental Health and Addiction Administration	 17 (57%) 6 (20%) 5 (17) 2 (7%)

(*Continued*)

Table 2 (Continued).

Characteristic	Statistics
Occupation, n (%):	
Registered nurse, leading specialist nurse, or social worker Clinical nutritionist, physical therapist, audiographer,	15 (50%)
or occupational therapist	7 (23%)
Medical doctor or manager	8 (27%)
Current job description, n (%):	
Direct patient care	19 (63%)
Management or special functions	11 (37%)
Education level, n (%):	
Master's degree	15 (50%)
Bachelor's degree	15 (50%)
Years working within the profession:	
Mean (SD)	16.9 (11.9)
Min-Max	0–40
Years working at this hospital:	
Mean (SD)	8.7 (8.4)
Min-Max	0–25
Employment, n (%):	
Permanent	27 (90%)
Temporary	3 (10%)
Full-time equivalent:	
Mean (SD)	98.7 (5.1)
Min-Max	80–100

and communication is essential for HL. One to three sub-themes were identified for each main theme. The themes will be presented with supporting quotes from the participants.

HCP Experiences With HL

HCP Perception and Understanding of HL Sensitivity

Data analysis revealed that HCP understand the meaning of HL differently, with some appearing not to understand the concept. One participant said that HL sensitivity depends on the patient's ability to acquire competency and less on

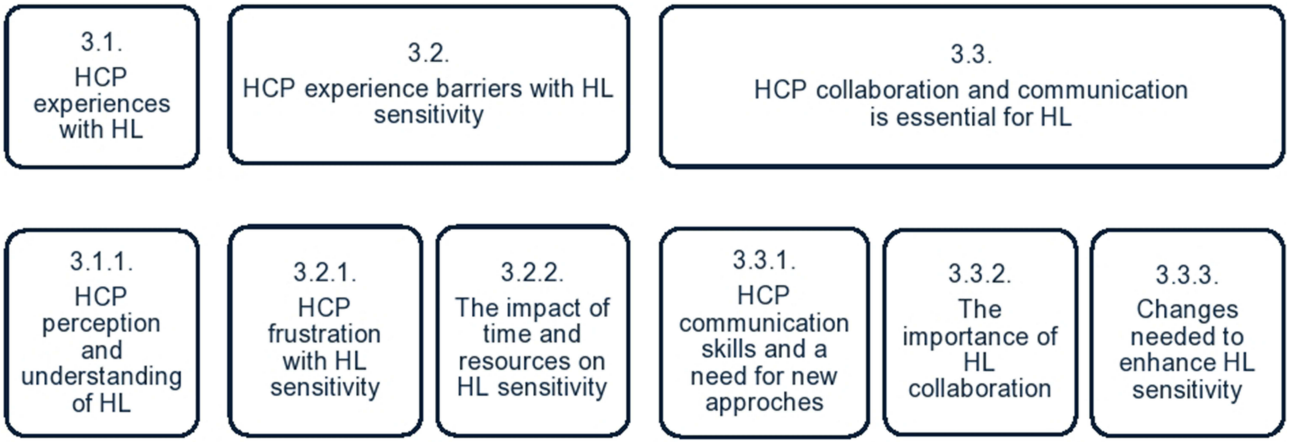

Figure 1 Overview of themes and subthemes from data analysis.
Notes: Three main themes were identified, with one to three sub-themes per theme.

Table 3 Participants' Supporting Quotes for Theme 1

Quote Numbers:	Illustrative Quotes:
Q1.	"I think of HL more as the patient's ability to acquire competence about health and to a lesser extent on what I convey to the patient." (participant (P): J)
Q2.	"I also think we overestimate our competence, that we know everything, we think we know what is important for the patient. When we first start asking, we may realize that we don't. It is a difficult field, especially on busy workdays." (P: M)
Q3.	"HL sensitivity is not necessarily convincing the patient to make the choices you would have made. That is not HL sensitivity. We just have to help them increase their understanding of the choice they make." (P: V)
Q4.	"I tried to have the same conversation again, and then I saw that he (the patient) was not responsive to my message. I then spent a lot of time, energy, and resources on this and spoke to the doctor. We understood at the end that we would not get through to him; then we just had to leave it and think we had done what we could. He was one of those who did not fit into our pattern or system, it became very clear." (P: A)

HCP's ability to convey it (Table 3: Q1). The HCP described a tendency for professionals to overestimate their own competence and assume they have all the answers. However, they stressed the importance of actively listening to patients, emphasizing that neglecting to do so could result in vital information being missed (Table 3: Q2). Participants agreed that HL sensitivity represents a central responsibility for HCP and that their goal for HL should be to guide patients. HCP do not wish to override patients' healthcare choices but rather to facilitate shared decision-making (Table 3: Q3). Several participants reported that the hospital lacked established routines for HL, placing responsibility primarily on the understanding and motivation of individual HCP. Lacking HL routines and guidance could become a considerable challenge for HCP, causing them to lose motivation (Table 3: Q4).

HCP Experience Barriers With HL Sensitivity

HCP Frustration With HL Sensitivity

HCP can experience difficulties and frustration when working with patients who have various HL levels. The HCP voiced that providing information to and receiving information from patients with low HL can be particularly difficult. This presents an added challenge, knowing that these patients rely on HCP for guidance and support (Table 4: Q6). In contrast, patients with higher levels of HL can also place high demands on HCP knowledge by demanding more information, leading to increased workloads (Table 4: Q7). Some participants experienced HL sensitivity as stressful and frustrating due to the time-consuming need some patients had for repeated information combined with high work pressure (Table 4: Q8). HCP emphasized the importance of being open-minded when working with patients with low HL and those from diverse cultural backgrounds. This approach could help prevent frustration from a lack of patience (Table 4: Q9).

The Impact of Time and Resources on HL Sensitivity

HL sensitivity poses systemic challenges in hospital care, where professionals experience limitations that hinder patient inclusion in decision-making (Table 4: Q10). HCP said they do not have enough time to follow up with patients in the way they would like, forcing them to take shortcuts and rely on et.al to bridge the gap (Table 4: Q11). New HL tools and routines aimed to lessen the HCP workload can sometimes cause difficulties and added workload; HCP explains that integration takes time and energy (Table 4: Q12).

HCP Collaboration and Communication Is Essential for HL

HCP Communication Skills and a Need for New Approaches

Some HCP expressed a desire to reorganize the timing and way information is given to patients. One participant noted that patients receive vast amounts of information from various interdisciplinary healthcare groups, which can be

Table 4 Participants' Supporting Quotes for Theme 2

Quote Numbers:	Illustrative Quotes:
Q6.	"Those who need us, and who need this information may just throw it away or use it as toilet paper. The ones we need an answer from are the ones who don't give it." (P: C)
Q7.	"If the patient has high HL, they will have many demands and a lot of questions. Doctor, have you thought about this and that, applied abroad, and all that? So truthfully, these patients can lead to a lot more work for me than those who do not have as high HL and kind of just accept what I say." (P: L)
Q8.	"I got annoyed when I was on 24-hour shifts at the hospital, and the fourth appendix came in at night, and you had been operating the whole time, and if they did not understand it (the information), the first, second, or third time, I got annoyed. I could not keep my calm and have a brilliant competence. I wanted to scream - Are you dumb? There will be irritation, and I think that is completely natural because there is high work pressure, high stress levels, and a fast pace. After all, we who work here are not glossy pictures; we get irritated." (P: H)
Q9.	"Yes, because it is easy to get irritated if you have not familiarized yourself with the situation. There may be patients with low HL or people from other cultures, you must remember that it is not something they are doing to be difficult. It's something we just must consider, but on a busy shift, we can get frustrated and irritated. It's a test of our patience." (P: P)
Q10.	"It is very popular to include the patient in all decisions nowadays, and it sounds incredibly nice, but unfortunately, healthcare is not always like that. It has some limitations and some assumptions that are difficult to work with." (P: C)
Q11.	"I often end up giving the patients a brochure just so I have done something because I do not have time for anything else. I do not have time for the conversation I was asked to have, and I want to do something so that brochure is better than nothing. I hope that someone else follows up." (P: Q)
Q12.	"I also feel that I cannot bear adding another new tool. It takes time. If there is something new, it definitely takes time with the patient because it takes a while before it becomes integrated. I can´t take it because it has been so incredibly busy for so long. Not being able to do things a bit automatically, I feel that I do not have time for that." (P: G).

overwhelming and difficult to comprehend (Table 5: Q13). Healthcare professionals acknowledge their role as facilitators in addressing patients' HL needs. They aim to meet patients based on their needs and preferences rather than presenting themselves as experts (Table 5: Q14).

Table 5 Participants' Supporting Quotes for Theme 3

Quote Numbers:	Illustrative Quotes:
Q13.	"Patients receive a great deal of information from many different interdisciplinary HCP groups, and we stand in a queue outside the patient room to provide all the information. I have noticed that when we meet them again in patient courses later, there is so much information they have not understood." (P: G)
Q14.	"The professional role is not just us holding all the answers. Perhaps rather someone who facilitates and constructs a framework creates opportunities and supports patients' wishes, more than being the expert. The professional role has changed." (P: I)
Q15.	"I do not only think about patients' HL, but also HCP. We must also assess et.al' HL sensitivity. If we notice that a et.al has given incorrect information or used old or incorrect sources, we must kindly correct them. HL competency is important both for HCP and patients." (P: K)
Q16.	"There is so much good that is done all around the hospital, but it is done so differently. It doesn't spread, and I wonder about that." (P: N)

(*Continued*)

Table 5 (Continued).

Quote Numbers:	Illustrative Quotes:
Q17.	"When we manage to be in advance and provide information, I experience that the patient feels a lot safer and calmer at discharge. Because it can quickly become a situation where we give information on the way down to the taxi, and that it is suboptimal." (P: Q)
Q18.	"Video consultations are the new thing or telephone consultations. It's absolutely horrible; you have nothing to anchor the information to. You only have a voice. Then you realize how much it means to sit face to face; how important it is to sit together." (P: C)
Q19.	"I think we benefit from talking with et.al about HL. We measure the patient's blood pressure and check many things, but do we talk about HL? Do we say that this is a patient with high HL or low HL? We must use the HL term when we talk to each other. That will make us more observant when informing patients that here I have to adapt and be more demonstrative. We must focus on it so that we remember it when we communicate with the patients." (P: A)

The Importance of HL Collaboration

Several HCP recognize the value of assessing their HL skills and creating a supportive environment where et.al can provide guidance and feedback. HL competency was perceived as crucial for patients and healthcare providers (Table 5: Q15). HCP were curious about why HL routines vary so much within the hospital and expressed a desire to share best practices (Table 5: Q16).

Changes Needed to Enhance HL Sensitivity

HCP reported that patients feel safer and calmer at discharge when information is provided in advance. Unfortunately, this is not always possible, and information is often given hastily under suboptimal circumstances (Table 5: Q17). Furthermore, new technology is altering how HCP address patients' HL needs. One participant highlighted that digitalizing HL sensitivity is demanding and creates a sense of distance between HCP and patients (Table 5: Q18). Some HCP suggested that discussing HL with et.al could be beneficial, wanting to put it on the agenda and use the HL term in clinical practice, believing it could help them in patient follow-up (Table 5: Q19).

Discussion and Conclusion

Discussion

In this study, we explored hospital HCP experiences with HL sensitivity in relation to work satisfaction and stress. Three main themes were identified. The first theme is *HCP experiences with HL* results reveal variability in HCP understanding of HL as a concept and some overestimating their competency. This could lead to obstacles for HL sensitivity and hinder HCP from providing individualized patient-centered care that addresses patients' HL needs. Previous research supports these findings, such as those of Toronto et al[17] describing challenges when nurses assess patients' HL needs and states that HCP may overestimate their own HL knowledge, causing difficulties for HL sensitivity. HCP are aware of their responsibility for providing information to patients, and they see their role as providing guidance and aim to facilitate shared decision-making. Karlsson et al[26] reported similar findings, noting that RNs strive to fulfill patients' desires by actively involving them in decision-making, listening attentively to their experiences, and valuing their perspectives. However, implementing this in clinical practice, where HCP experience stress and heavy workloads, is challenging. This is evident in the study by Flowers et al[25] showing that HCP burnout can be linked to reduced patient safety and satisfaction.

Our results also showed that HCP lacked routines to follow up on patients' HL needs effectively, which could lead to a loss of motivation among HCP to work on their HL sensitivity. Support and guidance are necessary for motivating HCP to mitigate work-related stress and remain in highly complex work situations.[21,39] It has been reported that nurses are motivated by challenges that leave them with positive feelings.[26] In contrast, our study shows that participants were not

motivated by these challenges; they reported wanting to avoid difficulties related to HL sensitivity. Participants explained that they experienced feelings of inadequacy when responsibilities were interrupted or left undone. HL is a complex responsibility, and HCP may need more training in HL sensitivity, guidance, and support to effectively follow up on patients' HL needs.

The second theme, *HCP experience barriers with HL sensitivity*, revealed challenges and frustration with HL sensitivity. Some HCP in our study described frustration when working with patients with various HL levels, overcoming cultural barriers, and struggling with increased workload and lack of time. Fortini and Daeppen[18] state that patients who do not follow HCP advice may threaten HCP's sense of competence and autonomy, making them feel powerless. HCP report feeling that their patience is tested by the frequent repetition of information, which sometimes causes stress. Stress can cause HCP frustration and reduced well-being, affecting their ability to care for patients.[6,25]

Some HCP experience systemic challenges and need time that is specifically earmarked for HL sensitivity. They wish to spend more time with patients to address their HL needs and collaborate with et.al to enhance their HL skills, which may reduce the stress associated with HL sensitivity. Both patients and HCP describe the lack of time for HL as frustrating, and inadequate time can result in HCP needing to prioritize their efforts.[23] Exhausted HCP spend less time with patients and remove themselves emotionally to conserve resources, which reduces individualization and involvement in care.[7] Given the global effort to enhance HL, HCP's responsibilities are unlikely to diminish. Therefore, healthcare organizations must ensure that their employees have adequate time and resources to improve HL in a manner that does not further burden HCP.

In the last theme, *HCP collaboration and communication is essential for HL*, results show that HCPs receive insufficient support for HL sensitivity, including a lack of help to develop their communication skills and facilities. This could cause barriers for HCP, hinder meaningful dialogue with patients, delay the integration of new knowledge, and increase stress. The study by Borge et al[23] supports these findings and describes HCP's need for communication skills and the ability to motivate patients. HCP should possess knowledge and use communication tools to effectively individualize HL sensitivity to patients.[8,23] HCP are seeking increased attention related to their HL sensitivity competencies and are enthusiastic about acquiring new knowledge about HL and communication techniques. Research shows that using communication techniques and HL strategies improves patient safety and is important for HCP achieving their professional responsibilities.[10,21] Karuanga et al's[16] findings are consistent with ours, showing obstacles to applying HL sensitivity in routine practice due to the lack of resources and time per patient. As emphasized by our participants and consistent with the findings of Fortini and Daeppen,[18] HCP need guidance to improve effective communication. HCP are willing to work hard to ensure HL sensitivity, but they do not have sufficient knowledge, tools, and support from management to make this happen. Results also revealed that HCP wish to increase collaboration throughout the organization to strengthen their HL sensitivity. Implementing collaborations across professions in clinical practices can be experienced as a challenge even though it is well-known that collaborations across professions positively influence the healthcare system and patients' health outcomes.[40] Participants in this study were surprised by how differently the hospital's departments addressed HL sensitivity, and they expressed a need for HL knowledge and routines to be shared throughout the hospital. Our participants identified increased use of the HL-term and attention on HL sensitivity as opportunities to strengthen both HCP's and patients' HL. Increased acknowledgement of HL sensitivity by management and empowerment of clinical HCP facing HL difficulties can be beneficial, knowing that HL sensitivity can be a demanding responsibility in complex work situations.[5,21,39] HL training, tools, routines, and support from management can enable HCP to better follow up on patients' HL needs and increase patient safety.[10,23,39] These changes require time and resources to be put in place, but when incorporated, they might improve the work conditions for HCP and strengthen patients' HL and health outcomes.

Trustworthiness and acknowledging limitations and strengths are crucial for research quality. The study's trustworthiness may be influenced by the authors' affiliation with the hospital where the research was conducted, as most authors are employed at that same hospital. One limitation is that this study was conducted in a single hospital; therefore, our results may not be transferable to other settings. Another limitation is that the transcripts were not returned to the participants, and therefore, the participants did not have the chance to validate the results. Additionally, our participants were highly educated and had long seniority, and thus, the results may not represent the wider HCP population. On the other hand, the

study was strengthened by the participants' interdisciplinarity and the fact that all focus groups included participants from direct patient care and management. Length of work experience was not an inclusion criterion, which is considered a strength, given that including participants with differing work experience expanded the variation and depth of discussion in the focus group interviews. We are conscious of the potential impact interviewers may have on participants during focus groups, therefore we varied group observers, minimizing the risk of influencing participants' discussions. Co-authors CRB and MHL both observed two focus groups. These experienced qualitative researchers supported both the participants and the main interviewer with their contributions. Individual coding and involving experienced researchers in data analysis are also strengths. Lastly, using the COREQ checklist is an added strength, as is the research group's commitment to fostering open discussions throughout the research process. This innovative study is the first qualitative research that explores HCP experiences with HL sensitivity, work satisfaction, and stress. Although we currently lack studies with which to compare our findings, this study will provide a foundation for comparison in future research.

Conclusion

The results of this study highlight a need for targeted interventions and organizational support of hospital HCP to overcome HL obstacles. By prioritizing communication strategies and incorporating HL tools, healthcare organizations may enhance HCP understanding of HL and lessen the strain associated with HL initiatives. HCP need guidance and recognition, and they want management to acknowledge that the current approach to HL sensitivity can cause them stress and frustration.

Practice Implications

We recommend that healthcare organizations pay more attention to HCP's needs when working to improve HL sensitivity. Organizations should strive to facilitate HL sensitivity in a way that does not impose additional stress on hardworking HCP.

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Authors` contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis, and interpretation, or in all these areas; took part in drafting, revising, or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and have agreed to be accountable for all aspects of the work.

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Disclosure

The authors report no conflicts of interest in this work.

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