

Consolidation of Acute Care Surgical Services: Learning from Patient Experiences

By

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ABSTRACT

Consolidation of Acute Care Surgical Services (ACSS) as a response to multiple challenges in providing timely and high-quality emergency services is a growing interest among healthcare policymakers. However, very little is known about patient experiences within this system. This study explores patient perceptions of their acute care surgical experiences within a consolidated ACSS program.

A qualitative study guided by the tenets of Appreciative Inquiry was conducted. Data were collected by means of semi-structured interviews and personal stories. Thirteen participants were involved, seven females and six males of varying ages; all underwent emergency surgeries including appendectomy, cholecystectomy, and small bowel obstruction surgery.

Findings suggest that clear and effective communication, excellent nursing care, timely access to surgical services, continuity of care, patient safety, transfer to an Acute Care Surgical (ACS) site, communication regarding transportation, and the process of admission to an ACS site play important roles in patient experiences within a consolidated ACSS.

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CHAPTER ONE: STATEMENT OF THE PROBLEM

Introduction

This introductory chapter outlines the purpose of the study, provides rationale supporting the need for the study, and describes the significance of the study.

Statement of the problem

Lack of timely access to high-quality acute surgical care is a growing concern in healthcare systems (Division of Advocacy and Health Policy, 2006; Russell, 2007). Multiple factors contribute to this situation including: a shortage of surgeons (Salsberg & Grover, 2006; Sheldon, 2007; Sanchez & Sariago, 2009), declining reimbursement for surgeons and their lifestyle considerations (Russell et al., 2007), and lack of willingness to disrupt an elective surgical practice (Austin et al., 2005; Maa et al., 2007; Roettger et al., 2005). In addition, increasing subspecialization in general surgery results in difficulty in providing expert care for emergency cases outside the field of a surgeon's specialty (Gough, 2008). Limitations in resources and unpredictability of access to operating rooms have made the provision of acute surgical care more complicated (Sorelli et al., 2008). This situation has led to problematic gaps in the emergency surgery call schedule at many institutions (Kreindler et al., 2010).

Surgical organizations worldwide have recognized these multiple challenges in the provision of emergency surgical services and have taken steps to initiate changes that serve the needs of patients and, at the same time, make it attractive and feasible to surgeons (The Committee on Acute Care Surgery American Association for the Surgery of Trauma, 2007; Bhagvan & Civil, 2009; Canadian Association of General Surgeons, 2009).

These challenges have been addressed through a variety of interventions such as developing an acute care surgery or "surgical hospitalist model," expanding and including emergency

general surgeries into an existing trauma centre, dedicating a twenty-four hour operating room to emergency surgeries, and regionalizing acute surgical services to certain sites within a multi-hospital system (Kreindler et al., 2010). The aims of these interventions has been to increase the attractiveness of trauma surgery among surgical residents (Kim et al., 2004; Schere & Battistella, 2004), increase general surgeons' job satisfaction (Kim et al., 2004; Kaplan et al., 2005), manage the shortage of resources (Dunsford, 2009; Hamilton et al., 1997), and improve delivery of acute surgical services (Austin et al., 2005; Pryor et al., 2004).

Different approaches for improving emergency surgical services are dependent on facility condition, surgeon caseload, and available resources. Consolidation of acute care surgical services (ACSS) to specific sites within a multi-hospital system has been a response to healthcare funding reduction, downsizing of community hospitals, closure of inpatient beds and operating rooms, and shortage of general surgeons (Dunsford, 2009; Hamilton et al., 1997). In a consolidated acute care surgery (ACS) model, all acute surgeries (non-trauma) have been directed to certain referral hospitals and managed by a dedicated acute surgical team, while elective general surgeries have been delivered in other locations, usually in community hospitals (Kreindler et al., 2010).

Implementing an ACS model in healthcare facilities is of growing interest to policy makers and surgeons (Ball et al., 2010; Wood & Panton, 2010, The Committee on Acute Care Surgery American Association for the Surgery of Trauma, 2007). However, very little is known about patient perceptions and their experiences with acute care surgery, particularly within a consolidated ACSS (Kreindler et al., 2010). Therefore, it is crucial to understand patient experiences and to highlight efficiencies or inefficiencies in a consolidated ACSS from the perspective of patients. This will assist in identifying sustainable solutions and developing more

effective acute care surgical services. Exploring patient experiences result in higher patient and staff satisfaction (Epstien et al., 2010), improved clinical outcomes (Isaac et al., 2010), and shorter hospital length of stay and reduced costs (Charmel & Frampton, 2008). Exploring patient experiences is also an essential step toward providing safe and high-quality care in an ACS model.

Purpose of the study & research questions

The main purpose of this qualitative research project, guided by the tenets of Appreciative Inquiry, is to explore how adult recipients of acute care surgery in the Winnipeg Regional Health Authority (WRHA) perceive the care provided to them in a consolidated surgical program. The research questions follow:

- (i) How do patients describe their experiences in a consolidated Acute Care Surgical Services (ACSS) program?
- (ii) How do patients perceive their overall care, access, communication, and safety within a consolidated ACSS program?
- (iii) What factors have shaped their experiences and perceptions?
- (iv) From a patient's point of view, what worked well, what could have worked better, and what changes would have been helpful in enhancing the quality of a consolidated ACSS program?

Significance of the study

This study will inform policy makers and healthcare professionals about patient experiences within a regionalized acute care surgery program and assist them to gain a greater understanding of how acute surgical patients perceive the overall quality of care, access, communication, and safety in a consolidated ACSS program.

The findings of this research project will assist in planning and improving acute surgical services in the future and has the potential to increase patient satisfaction. The findings may also contribute to developing educational programs for healthcare professionals and designing a context-specific survey to assess patient experiences.

Summary

This chapter has provided an introduction to the study, described the statement of the problem, and defined the purpose of this research study. Since very little is known about patient experiences in a consolidated ACSS, the aim of this study is to understand how patients undergoing emergency surgeries perceived the care provided to them in the consolidated ACSS. The following chapter will discuss a review of the empirical literature related to the study.

CHAPTER TWO: REVIEW OF LITERATURE

Introduction

This chapter provides an overview of the literature related to the acute care surgery (ACS) model and to patient's experience with their subsequent surgical care. A comprehensive literature review related to patient experience with surgical services was not conducted prior to conducting interviews in order to allow the findings to emerge from the qualitative data. After completing a preliminary analysis of the interviews, a search was conducted to locate relevant literature on the topic of patient experience with emergency surgical services. It became apparent that there are few studies solely focused on the experience of patients in acute surgical services. Furthermore, studies on patient surgical experiences within consolidated acute care surgical services (ACSS), employing qualitative methods, are particularly rare. This paucity in existing literature led to an extensive search for articles on patients' experiences with any surgical procedure, including elective and ambulatory surgeries, and with an emergency department.

The first part of this chapter will look at the ACS model, and its impact on surgical patient outcomes; the second component of this section will provide an overview of existing literature associated with patient experiences, particularly in surgical services.

Acute Care Surgical Services (ACSS)

The Acute Care Surgery (ACS) model in Canada has been identified as:

“The urgent assessment and treatment of non-trauma general surgical emergencies involving adults. More specifically, this model of health care delivery surrounds the optimal treatment of intra-abdominal surgical crises ... [and] include, but are not limited to, acute appendicitis, cholecystitis, diverticulitis, pancreatitis, intestinal obstruction, intestinal ischemia, intra-abdominal sepsis, incarcerated hernias and perforated viscous.” (Ball et al., 2010, p.84)

This model of surgical care has been initiated in thirteen health care facilities across Canada including Vancouver (one hospital), Edmonton (two hospitals), Calgary (two hospitals), Winnipeg (three hospitals), Toronto (two hospitals), Ottawa, Montreal, and Halifax (Hameed et al., 2010).

The Acute Care Surgery (ACS) model provides in-house surgical coverage, rather than consultation by phone, through a dedicated rotational team of general surgeons who do not have any immediate elective surgery commitments (Kreindler et al., 2010). The designated surgeons and house staff are responsible for providing comprehensive surgical care from a patient's arrival at the emergency room to their discharge. At the end of each surgeon's ACS rotation, the usual duration of which is one week (Ball et al., 2010), a surgeon's duty to provide ACS will be ended; if their patients' treatment is not completed, these patients will be handed over to the next rotation of ACS surgeons (Hameed et al., 2010). The most common acute surgeries performed in an ACS model are appendectomy, cholecystectomy, tracheostomy, percutaneous gastrostomy, colectomy, and repair of abdominal injury (Britt et al., 2009).

Impacts of Acute Care Surgery Model

Several studies have shown that the ACS model provides improved access to acute surgical care and enhances patient outcomes. Earley and colleagues (2006) examined clinical outcomes of patients with acute appendicitis in an ACS model. The ACS model in this study referred to a trauma center where trauma surgeons were responsible for twenty-four hour on-site consultation. This study reported that as a result of the availability of on-site surgeons, rupture rate, complication rate, and time to operation were significantly decreased; length of the average hospital stay was also reduced compared to a traditional on-call model of surgical services.

Authors of the study concluded that the ACS model improved the clinical outcomes of patients with appendicitis (Earley et al., 2006).

Similarly, patients with acute cholecystitis have also been shown to benefit from the ACS model, experiencing shorter length of hospital stay and fewer complication rates as a result of on-site consultants (Lehane et al., 2010). A study evaluating the outcome of the implementation of a “surgical hospitalist model,” one year post-implementation, illustrated shorter emergency room stays, improved patient satisfaction, enhanced professionalism, improved resident supervision, and better overall quality of care (Maa et al., 2007).

In another study, Parasyun and colleagues (2009) examined the outcome of implementing an ACS model including a four-bed surgical ward with an operating theatre, which was controlled by a scheduled acute-care surgeon. The researchers collected data over seventy-nine weeks of the ACS initiative and compared the outcomes of the implementation with the previous on-call system. The implementation of the ACS model resulted in more efficient use of operating rooms such as high operating room utilization and fewer operations after hours. They also concluded that an on-site surgeon in the ACS model provides a more efficient and safer environment for treating patients and training future surgeons, as well as improving surgeons’ lifestyle and staff satisfaction (Parasyun et al., 2009). Similar results were provided by another study assessing the creation of an ACS model and integration of trauma, critical, and emergency surgeries. This study showed the ACS model supports excellent patient care, increases physician job satisfaction, and better controls of the need for after hour surgeries (Garland et al., 2007).

The effect of the creation of Acute Care Surgical Services (ACSS) on surgical patient flow at the hospital level was assessed by other researchers through a medical chart review of patients who were admitted for acute appendicitis, acute cholecystitis, and small bowel obstruction,

before and after the ACSS implementation to an ACS site. This research illustrated that the implementation of ACSS increased the volume of patients treated for appendicitis, cholecystitis, small bowel obstruction, and improved timeliness of surgical care including faster surgical assessment and a shorter period of time from admission to discharge (Faryniuk & Hochman, 2009).

A recent study examined the impact of consolidation of ACSS to specific sites within a multi-hospital system. This study reported that the number of transferred patients and wait times for acute surgery increased after the ACSS consolidation. The increased wait times were mostly for patients who presented at non-referral sites; transferred patients waited 5½ hours longer than non-transferred patients. The findings of the study indicated that no patient harm or injury was associated with the implementation of the ACSS. Furthermore, this study demonstrated that consolidation of the ACSS did not appear to change patient care outcomes as measured through: readmission rate, mortality rate, complication rate, time of surgery, and hospital length of stay. This study concluded that the consolidation of the ACSS provides adequate emergency surgical coverage without compromising patient care or threatening patient surgical outcomes (Kreindler et al., 2011).

Acute Care Surgery Model: Surgeons and surgical staff perspective

From the surgeon point of view, the ACS model has significant implications for the education of medical students and surgery residents (Jurkovich, 2007) and improves general surgery resident skills and techniques (Stanley, 2011). The ACS model also provides general surgeons with an opportunity to focus on their elective surgeries when they are not engaged in acute surgical services (Ball et al., 2010; Hameed et al., 2010). Furthermore, working on a predictable schedule in the ACS model allows for a more controllable and satisfactory lifestyle,

and increases surgeon willingness to pursue his/her specialty in acute care surgery (Jurkovich, 2007).

A survey study of 155 surgeons, including attending trauma surgeons and residents, indicated that they believed the ACS model provides opportunity to maintain their surgical skills; however, there was a mixed view on the effect of the ACS model on resident interest (Tisherman et al., 2011). Another study pointed out, despite receiving comprehensive clinical experience in an ACS setting, general surgery residents faced a “high incidence of burnout” due to the excessive volume of services (Kholdebarin et al., 2011).

Although surgeons benefit from the ACS model, the largest beneficiaries of the ACS model are patients (Jurkovich, 2007); however, there are uncertainties regarding the effects of consolidation of the ACS on patient access, especially for patients who are transferred between hospitals (Kreindler et al., 2010). Surgeons also highlighted acute surgical patients as “uniquely vulnerable to medical error” since they do not have “an opportunity to benefit from ideal preoperative physiologic or medical optimization” (Hameed et al., 2010, p.80).

An internal evaluation of an ACS site reported that there were some challenges and concerns regarding communication, safety, and efficiency of patient care from the staff perspective (Dunsford, 2009). In this evaluation, some qualitative data was collected through observation and discussion with the ACS site staff such as clinical managers, nurses, anesthesiologists, general surgeons, physiotherapists, and support staff in operating rooms and inpatient wards. The ward staff expressed that communication among surgeons, operating room staff, and sending facilities remained “poor.” The nurses stated that they were not able to provide “safe care most days” to ACS patients (Dunsford, 2009, p.17). Allied health professionals such as physiotherapists indicated that there was pressure to discharge patients rapidly, which means “patients were going

home sicker” (Dunsford, 2009, p.17), and there was not enough time for their intervention. The staff also specified that multiple transports for a patient which might involve transport from an original site to another hospital to receive a diagnostic tests, then a subsequent trip back to the original site for surgery, is a “waste of time.” In this evaluation, a number of ACS patients were also interviewed. The patients reported generally positive experiences with the ACS services. However, some of the patients said they did not know exactly who their physician was, and patients who were transferred from another hospital expressed concerns that their family was not provided with adequate information prior to and after the transfer (Dunsford, 2009).

Patient Experience

Patient experience has been recognized as a top priority in healthcare systems (The Beryl Institute, 2010). It is one of the important components of quality of care (Darzi, 2008) and health services evaluation (Garratt et al., 2008). Exploring patient experiences at various stages in their path through a healthcare system has led to successful delivery of high-quality services (NHS Confederation, 2010). Several studies have shown that when patient experience is a high priority within healthcare organizations, better outcomes are achieved across the entire organization (NHS Confederation, 2010), including higher patient and staff satisfaction (Epstien et al., 2010), improved clinical outcomes (Isaac et al., 2010), and shorter hospital length of stay and reduced costs (Charmel & Frampton, 2008). This has prompted greater interest in understanding and measuring patient experience at different levels of the healthcare system (Balik et al., 2011; Bleich et al., 2009; Goodrich & Cornwel, 2008).

Definition of Patient Experience

In the existing literature, the term ‘patient experience’ is often used interchangeably with patient satisfaction. Patient experience has also been recognized as a component of patient

satisfaction, along with patient expectations, patient characteristics, and health status (Chow et al., 2009). A simple definition of patient satisfaction would be “the degree to which the healthcare experience meets patient expectations” (Chow et al., 2009, p.436) or “patients’ reflections upon and satisfaction with their lived hospital experiences” (Henderson et al., 2004, p.74). Patient expectations, as beliefs, desires or wants about an event such as surgical procedures that will take place in the future, involve a broad range of the outcomes of surgery, from specific symptom relief to general life-style improvement, and includes both “cure” expectations and “care” expectations. In other words, patients expect to “get better” and “be treated well” (Jones et al., 2000).

Some research indicates that patient perceptions of satisfaction is not a comparison between expectations and experience, but is “whether or not the experience was better or worse than expected” (Williams et al., 1998, p.1352). Patient satisfaction includes both cognitive and emotional facets, and is a person’s attitude toward the total experience of healthcare; it relates to patient demographic and social factors, expectations, and previous experiences in the healthcare system (Grimes, 2003). There is no doubt that there is a relationship between the experience of care and satisfaction with it; however, to what extent patient experience explains satisfaction of quality of services or vice versa still remains unclear (Bleich et al., 2009). In particular, high patient satisfaction does not necessarily indicate that the patient had a positive experience (Bowen, 2006; Williams et al., 1998).

Patient experience is identified as “results from a subjective process that is informed by their [patients] life experiences” (Henderson et al., 2004, p.74). Other studies referred to patient experience as a measure of “patient-centered care”. Patient-centered care explains an approach that consciously determines patients’ perspective through identifying and measuring patient

experience in a healthcare system. Patient-centered care contains the following eight essential dimensions: access; respect for patients' values and preferences; coordination of care; information, communication, and education; physical comfort; emotional support; involvement of friends and family; and preparation for discharge and transitions in care. Patient-centered care focuses on patient self-identified needs and concerns (Balik et al., 2011; Picker Institute, 2011).

The World Health Organization has used the term "responsiveness" to determine and improve patient experience. The term "responsiveness" refers to aspects of care that relate to how and in which environment patients are treated. It has been built on a need to capture people's actual experience within a healthcare system. The concept of responsiveness also has been described using eight domains including: respect for the dignity of persons, autonomy to participate in health related decisions, confidentiality, prompt attention, adequate quality of care, communication, access to social support networks, and choice of healthcare providers (Bleich et al., 2009).

The Oxford Dictionary defines "experience" as "an event or occurrence which leaves an impression on someone" as well as "practical contact with and observation of facts or events". In my study, patient experience refers to the knowledge of patients who underwent acute surgical care and the impressions they gained from what actually happened during this episode of care.

Measuring patient experience

Patient satisfaction tools, most commonly surveys, attempt to capture patient perceptions of the quality of care delivered by a program, a service, a healthcare facility, or a healthcare system as a whole (Bleich et al., 2009). However, it has been shown that standard patient satisfaction questionnaires might not be adequate to measure patient experiences of healthcare delivery

(Dougall et al., 2000) and may not be the most appropriate method for identifying areas for quality improvement (Bleich et al., 2009; Sizmur & Redding, 2009).

Satisfaction surveys usually provide a partial picture of patient experiences and may not provide sufficient depth of information to understand a patient's knowledge of what they have actually undergone throughout their care process. While patient satisfaction surveys obtain ratings of satisfaction with care, patient experience surveys gather information on what patients did or did not experience in their interactions with providers and the healthcare system. The European Picker Institute (2009) has differentiated between patient satisfaction surveys and patient experience questionnaires and indicates that:

“Satisfaction questions tend to ask patients to give subjective responses, in the form of ratings on a scale (from ‘poor’ to ‘excellent’, for example). They have been found to be unreliable, and they do not provide specific factual information that can be used to improve quality.

Patient experience questions, by contrast, ask patients to give factual responses to questions about what did or did not happen during an episode of care. By examining specific issues they provide a better guide to where the service provider is performing well or poorly, and hence which areas of performance should be addressed.” (Sizmur & Redding, 2009, p.5)

Limitations of measuring patient satisfaction including problems related to its concepts and methods has led to developing other strategies for learning from patient experiences and optimizing opportunities to listen to patients (Bowen, 2006). Measuring patient experience is as important as measuring clinical outcomes. Excellence in clinical outcomes is a critical component of a patient's experience, but may not always relate to how patients feel. Thus, clinical outcomes are not sufficient to achieve an excellent experience. Excellent experience is also determined by the physical environment patients occupy, patients' feelings about the care they receive, and the way staff interact, treat, and care for them (NHS Confederation, 2010). The

value of involving patient voices in a dialogue about their experience within a healthcare facility is immense and assists healthcare planners, managers, and policy makers to create a caring and supportive healthcare environment and to enhance healthcare services based on patient needs (NHS Confederation, 2010).

As healthcare facilities strive to provide high-quality care for patients, improving patient experience is not an easy task. Patient experience can involve an extensive range of aspects of the care experienced by patients in a healthcare organization. To understand this process, every aspect of a patient's journey must be explored; the first place they sought healthcare services, their initial contacts with the healthcare system, their treatment experience, their discharge, and their re-adjustment to the community and normal life (Sizmur & Redding, 2009). Patient experiences with and perceptions of waiting times, the quality of basic amenities, and communication with healthcare providers help to identify tangible priorities for improvement. Patient experience provides a direct link to action to improve quality of care (Sizmur & Redding, 2009).

Patient experiences with surgical services

Studies of patients undergoing surgical procedures and their experiences are abundant in the literature; however, elective and ambulatory surgeries have been the focus of most of this research (Barthelsson et al., 2003; Costa, 2001; Gilmartin, 2007; Gilmartin & Wright, 2008; Henderson et al., 2004; Jones et al., 2000; Letterstal et al., 2010; Mitchell 2005; Mottram 2011; Rhodes et al., 2006). These studies deal with patients' experiences and their perceptions of pre-operative and post-operative care, pain management, and patient expectations of the outcome of the surgical procedures.

A phenomenological study of sixteen patients who underwent abdominal surgical procedures in an ambulatory surgery center identified three common themes: “fear,” “knowing,” and “presence.” “Fear” referred to anxiety arising from being cut, fear of anesthesia, and dying from surgery. “Knowing” referred to being informed about the surgical experiences throughout the whole process of pre-operative, post-operative, and recovery at home, as well as being treated with dignity and respect. “Presence” included the presence of nursing staff and family members to provide physical and emotional support. Patients in this study felt comfortable about the information they received from surgeons and described it as clear. Although the provision of information regarding surgical procedures appeared sufficient, patients were not adequately informed about the process of care in the pre-operative and post-operative stage. The study also reported that patients suffered from inadequate pain management and were not well prepared for discharge (Costa, 2001).

Another hermeneutic phenomenological study of twenty patients experiencing gynaecological, urological, and general surgery described patient experiences with day surgery using four main themes: first, “the feeling of empowerment during preparation” that referred to receiving explanations and reassurance regarding the surgical procedure and treatment from healthcare professionals, especially surgeons and anesthetics. Second, “the apprehensions encountered” included the potential threats and fear associated with having general anesthetic and undergoing the surgical procedure. Third, “the feeling of abandonment in the preoperative waiting area” referred to participants’ feelings of neglect and distress during pre-operative wait. Fourth, “the dynamics of recovery” referred to patient descriptions of post-operative care, mostly clinical symptoms and their discharge plan. This study concluded that the psychological effects resulting from time waiting in the pre-operative phase, along with patient anxiety undergoing

surgery, affect patient experience tremendously. The study suggested that healthcare professionals, particularly nursing staff, should provide strong and ongoing emotional support to reduce patient anxiety. This study also highlighted the importance of environmental factors such as music in reducing patient anxiety (Gilmartin & Wright, 2008).

In another qualitative study, descriptions of patient experience with laparoscopic cholecystectomy in a day surgery environment were categorized into four main themes: “living with gallstone problems,” “experiences on the day of surgery,” “experiences during the first week after surgery,” and “return to activities of daily life.” This study reported that patient work life and social contacts were severely affected with gallstone disease; all were eager to undertake the surgery. The study also indicated that continuity of care, “meeting the doctor who is going to do the operation,” increased patients’ level of comfort and safety and decreased their anxiety. Furthermore, this study indicated that patients experienced various degrees of pain after surgery and during recovery at home. However, they were able to resume their normal life activities after approximately one week. This study highlighted that reducing pre-operative anxiety, providing adequate and appropriate pain management, particularly after surgery and following discharge, and presenting sufficient information about wound care had significant effects on patient experiences and perception of quality care. Participants in this study also wished for further telephone follow-up from the hospital (Barthelsson et al., 2003).

Henderson and colleagues (2004) conducted a qualitative study with twenty patients who underwent elective surgeries and identified sixteen different areas that were important to make patients hospital stays satisfactory. The most important factor mentioned by participants in this study was “hotel services” including cleanliness, fresh air, food, bathroom facility, bedding, heating, noise level, and parking. This indicates the importance of environmental factors for a

comfortable stay in a hospital. The next important factors were “medical outcomes” and “provision of information.” Patients in this study commented on the importance of being fully informed about their “illness, treatment, and medical outcomes” continuously and clearly, and emphasized “an explanation - not just be a string of facts.” Compassion, pain relief, waiting time, and emotional support were other aspects that played substantial roles in patient perceptions of a satisfactory hospital stay. “Access to care” referred to long waiting times before scheduling for surgery, uncertainty of contact for surgery, and potential cancelation. Other important aspects of the hospital experience mentioned by participants were discharge, friendly staff, respect, communication, and patient involvement in their care. Although communication was not cited as a “dominant theme,” the majority of patients indicated the importance of provision of information to a satisfactory hospital stay. The study concluded that a combination of factors is required to make patient’s hospital stay satisfactory, and highlighted the unique experiences of each individual patient (Henderson et al., 2004).

Patient experiences within an emergency department (ED) have been also explored through several studies. For instance, Narin and colleagues (2004) identified six core themes within the literature regarding the assessment of patient experiences in the ED including: wait times, communication, cultural aspects of care, pain, the ED environment, and “dilemmas in accessing patient experience.” Another study by Taylor and Bengner (2004) showed that the most frequent and important factors influencing patient satisfaction in emergency medicine were interpersonal skills or staff attitude, provision of information and explanation, and waiting times. A recent systematic review of qualitative studies on patient experiences within the ED demonstrated emotional impact of the emergency, staff-patient interactions, waiting times, presence of family

in the ED, and emergency environment as the five dominant themes with considerable impact upon the patient experience within the ED (Gordon et al., 2010).

There is growing evidence that communication skills are a core competency in medicine, and the way healthcare professionals communicate and interact with patients has a profound impact on patient psychosocial adjustment, satisfaction with care, involvement in decision making and relationships with healthcare professionals (Klein, 2005; Rodin et al., 2009; Street et al., 2005). Physician communication skills such as honesty, openness, and timeliness of communication have been recognized as among the most important factors in alleviating patient psychological distress (Rodin et al., 2009). Furthermore, there are specific physician behaviors which increase the likelihood that patients perceive physicians as caring, such as showing empathy and compassion; the non-verbal aspects of communication are as important as the verbal (Rodin et al., 2009).

Despite significant evidence suggesting empathy as a major skill for physicians, valued most by patients, a majority of physicians fail to show sufficient empathy toward their patients (Kim et al., 2004; Levinson et al., 2000; Street et al., 2005). For example, Levinson and colleagues (2000) reported that patients' emotional clues were responded to by only 21% of physicians in primary care and 38% in surgical care. They also indicated that opportunities to acknowledge patient feelings and emotional needs were often missed by physicians. Street and colleagues (2005) showed that 84% of patients initiated active participation in their medical communication, rather than this communication being prompted by physicians. Inadequate physician communication skills often result in uncertainty, confusion, low patient confidence, poor health outcomes, and low patient satisfaction (Bruera et. al., 2001)

Communication is typically viewed as a fundamental nursing skill used in assessment, therapeutic intervention, and patient education (Williams & Gossett, 2001). Nurses' communication style is often different than physicians. Nurses usually explain procedures ahead of time, and begin the communication with some form of acknowledgment of the patient's permission (Williams & Gossett, 2001); however, physicians often provide information about the procedure while they are beginning the procedure (Rhodes et al., 2004). The main patterns of nursing communication style include assessing what the physician has told the patient, encouraging patients to seek clarification from the physician, encouraging the patient to obtain a second opinion, and reassuring patients about the physician's competency. Nurse-patient communication directly or indirectly influences and clarifies communication among patients and the physicians (Williams & Gossett, 2001).

Nursing staff also play a key role in the development and maintenance of interpersonal relationships with patients that increase patient comfort and security, decrease patient anxiety, and enhance patient personal wellbeing through listening and encouraging them to express their fears (Blockley & Alterio, 2008; Costa, 2001). Development of a positive relationship with patients is essential to high quality nursing care delivery. Nurses who appear cheerful, sincere, and compassionate are more likely to establish a positive relationship with their patients (Blockley & Alterio, 2008).

The importance of listening to patients, giving patients enough time to talk, keeping them well-informed, and responding to their needs quickly are major themes of patient experiences within the nursing care literature (Ahmad & Alasad, 2004; Blockley & Alterio, 2008; Costa, 2001; McCabe, 2004). Patients value the "nursing presence," defined as the "capacity to listen, be perceptive to the environment, and anticipate patients' needs" (Costa, 2001, p.880). Blockley

& Alterio (2008) showed that patients value the provision of care and the support offered to them by nursing staff and appreciate nurses' interpersonal skills as highly as technical skills. Patients valued nursing staff who listened and perceived them as "human beings" (Blockley & Alterio, 2008).

A survey study of 225 patients from medical-surgical wards at a teaching hospital reported that 74% of patients had positive experiences with nursing care; patients considered time nurses spent with them as adequate (63%), speed of nurse response as quick (61%), awareness of patient needs as well as the help relatives and friends received from nurses as adequate (67% and 83%); however, the provision of information was perceived as inadequate. This study concluded that the speed of the nurse response to patient call, time spent with patients, and amount of information nurses gave to patients were significant predictors of patient experiences with nursing care. Authors of this study also indicated that nursing staff and patients might have different expectations respecting speed of nurse response to patient call or the time nurses spend with patients (Ahmad & Alasad, 2004).

Another phenomenological study explored patient experiences of how nurses communicate with patients and reported four main themes: "lack of communication," "attending behaviour," "empathy," and "friendly nurses" (McCabe, 2004). Some patients in this study indicated that nursing staff did not provide adequate information, but were more concerned about their tasks than talking to the patients. Some other patients appreciated nurses' honesty and their accessibility for listening to them. "Communication with empathy" referred to nursing engagement and support of patient emotional needs. Participants in this study also acknowledged nurse friendliness and humor (McCabe, 2004).

Provision of information regarding the process of care and treatment were reported to have a significant impact on patient's experiences, especially in an emergency department (Gordon et al., 2010). The amount of information provided, clarity of messages, and tone of voice used by healthcare providers influence the relationship among patients and healthcare providers (Gordon et al., 2010). Timely and appropriate information provides patients with a clear picture of what to expect and alleviates their anxiety (Costa, 2001). The level of information that patients need and how they retain the information is often different; therefore, the provision of information should be modified, based on individual needs (Mitchell, 2001).

Literature suggests that different sources of information exist for patients in emergency department and surgical settings, including verbal information by healthcare professionals and printed literature (Blay & Donoghue, 2006; Gordon et al., 2010). Although, surgical patients can receive information from multiple sources, the primary source of information is their medical practitioner (Blay & Donoghue, 2006). Verbal explanations are the most important means for providing information, particularly in the pre-operative stage. Face-to-face conversation along with an interpersonal relationship among patients and healthcare providers have been identified as the most effective ways of providing and exchanging information leading to improved patient satisfaction (Mordiffi et al., 2003).

A survey study reported that patients who underwent an elective laparoscopic cholecystectomy received information mainly from their surgeons and other hospital doctors regarding the procedure and hospital length of stay. Post-operative pain information was mostly provided to patients by anesthetists and hospital doctors rather than surgeons or nurses. Pre-admission clinic nurses more likely provided information related to surgical procedures, but were not mentioned as a major source of information. Additional sources of information identified by

patients were pamphlets, the internet, and medical books. Seventy-three per cent of patients in this study were satisfied with the information provided to them; however, 22% of patients indicated that the provision of information was not sufficient and requested additional information regarding diet (13%), self-care after discharge (9%), general pre-operative information (9%), surgery related information (6%), post-operative activities (6%), pain management (4%), and medical terminology (1%) (Blay & Donoghue, 2006).

Clear and effective communications between patient and care provider, as well as among healthcare professionals, play a vital role in patient safety. The Joint Commission on Accreditation of Healthcare Organizations identified that one of the requirements for patient safety is effective communication among healthcare providers (The Joint Commission on the Accreditation of Health Care Organizations, 2009). Many medical errors were attributed to failed communication or lack of effective exchange of information (Miner, 2002). Improved communication is a key element to not only reducing patient anxiety, improving healthcare provider relationships with patients, but also to providing a safe environment for the ongoing provision of care (Miner, 2002; The Joint Commission on the Accreditation of Health Care Organizations, 2009).

To provide safe and successful surgical experiences, pain management should be identified and initiated during primary assessment in the pre-operative stage and targeted to individual patient needs (Kamming et al., 2004). Effective pain management results in improved patient clinical outcomes (Chavis & Duncan, 2003) and appropriate assessment and diagnosis of post-operative pain is important to reduce suffering for patients (Sherwood et al., 2003).

Waiting for care as a “number one barrier” to access healthcare services creates many difficulties for patients and their families. A survey study indicated that seventeen to twenty-nine

per cent of patients considered the waiting times to access healthcare services such as diagnostic tests, specialist visits, and non-emergency surgeries as unacceptable. Long waiting times affected levels of stress, anxiety, and pain and was a burden on daily living activities (Sanmartin et al., 2006). A report from Royal College of Physicians in the United Kingdom (2002) on acute medical services explained that lack of on-site diagnostic services and surgical residents caused delays in obtaining surgical opinions and diagnostic investigations, and often led to transfers for surgical opinion and imaging investigations. This report indicated that acutely ill patients should not be admitted to hospitals which do not have critical care and appropriate diagnostic services and recommended a 24-hour diagnostic service and critical care needs to be available in hospitals (Connor, 2002; Royal College of Physicians, 2002).

Inter-hospital transfers, transferring patients from one hospital to another, as an inevitable part of emergency department (ED) processes is potentially risky but may be necessary as a result of the need for specialist investigations or interventions that are unavailable in an originating hospital (Ahmed & Majeed, 2008; Dunn et al., 2007). Inter-hospital transfers may result in more overcrowding of the ED and reduce the efficiency of the ED at the receiving hospital (Bertazzoni et al., 2008). Overcrowding in ED causes adverse effects on patient experiences, quality of care, and pain management (Collis, 2010).

The number of inter-hospital transfers appears to have increased considerably due to the regionalization of specialist services (Ahmed & Majeed, 2008, Kreindler et al., 2011). Inter-hospital transfer causes already vulnerable patients and those seriously ill to be even more anxious. Unusual movement during transfer increases pain and nausea (Ahmed & Majeed, 2004; Dunn et al., 2007). Inter-hospital transfers usually occur during out of normal work hours and patients are often accompanied by junior staff (Dunn et al., 2007).

Throughout the inter-hospital process several steps should be considered carefully for a safe and timely transfer. Dunn and colleagues (2007) described these steps as “pre-transfer stabilization, transfer personnel, transport preparation and equipment, communications, and hazards during transport.” Clear communication among referring hospital, transfer team, and receiving hospital are crucial elements to safety of transfer and avoidance of unnecessary delays and harms. Effective communication between the referring and the receiving hospitals must be in place prior to any transfer arrangement and include information regarding “patient condition, investigation and treatment plans, method and timing of transfer, agreed destination, and the acceptance of admission to the receiving hospital” (Dunn et al., 2007. p.42). Written communications are as important as verbal communications in a safe inter-hospital transfer; written communications should include a copy of patient medical records, diagnostic results, and details of the transfer process. Keeping patients and their family fully informed about the transfer at all times is another fundamental part of inter-hospital transfer communications (Dunn et al., 2007).

According to Wallace & Ridley (1999) a safe transfer depends on “experienced staff, appropriate equipment and vehicle, full assessment and investigation, extensive monitoring, careful stabilization of patient, reassessment, continuing care during transfer, direct handover, and documentation and audit” (p.368). Several risk management and safety guidelines have been developed to assure the safety of patient transfer; however, all aspects of the recommended guidelines might not be applied by hospitals transferring patients (Ahmed & Majeed, 2008). Ambulances may experience mechanical failure, traffic accidents, and other unexpected events. Although, the risk of ambulance breakdown or road accident is very low, it is possible (Ahmed & Majeed, 2004). Therefore, an assessment of the potential risks and benefits to the patient as

well as anticipation and management of possible hazards is essential prior to any transfer (Ahmed & Majeed, 2008; Dunn et al., 2007).

Summary

This review of the literature provided a holistic picture of the ACSS model and patient experience. This perspective demonstrated several reasons for implementing ACS model such as shortage of surgeons, lack of willingness to disrupt an elective surgical practice, increased subspecializations, and surgeon's lifestyle considerations. This review also identified benefits and impacts of implementing ACS model on surgeons and patients including improved access to acute surgical care and better clinical outcomes for patients, increased surgeon satisfaction, enhanced educational opportunities and surgical skills for general surgery residents. At the same time, this review highlighted uncertainties regarding the effects of regionalization on patient access and surgical outcomes and emphasized the importance of understanding patient experiences in a consolidated ACSS. Differences between patient satisfaction and experience were highlighted, and several dominant factors affecting patient experiences especially within surgical services and ED such as communication, access, respect, physical comfort, and emotional support were underlined.

CHAPTER THREE: METHODS

Introduction

The purpose of this chapter is to describe the qualitative research methods used in conducting the study and to outline procedures used in completing the research. The chapter begins with research setting, main purpose of study and a brief overview of the importance of qualitative study, followed by an introduction to Appreciative Inquiry and its principles as a theoretical framework. The specific steps for data collection and analyses of the data are also described in detail. The chapter concludes with the researcher's strategies for achieving study rigor, obtaining ethical approval, and an outline of the study's limitations.

Research setting

This research was conducted in the Winnipeg Health Region which serves residents of the city of Winnipeg as well as the rural municipalities of East and West St. Paul, with a total population of just over 700,000 people. The Winnipeg Regional Health Authority (WRHA) also provides health care support and specialty referral services to residents of north-western Ontario and Nunavut (Winnipeg Regional Health Authority, 2011).

The Winnipeg Regional Health Authority offers a variety of surgical services including cardiac, neurological, orthopaedic, paediatric general, plastic, thoracic, urology, vascular, oral, ophthalmological, and general surgery as well as burn treatment. There are six acute care hospitals in the Winnipeg Health Region, two tertiary care and four community hospitals (Winnipeg Regional Health Authority, 2011). Surgical programs and services offered at each of the hospitals are variable. Some of the surgical programs and services are consolidated and, therefore, may not be offered in all the hospitals located in the city of Winnipeg.

Emergency general surgical services in the Winnipeg Health Region have been consolidated since April 2008 in order to better cope with the shortage of surgeons to take emergency calls at each hospital. In consolidated acute care surgical services (ACSS), emergency general surgeries have been provided in three sites of which two are referral sites for other hospitals in the Winnipeg Health Region. The third acute care surgical site which provides tertiary services and is a designated trauma centre has always accepted acute care surgical patients, but it is not a referral site for other hospitals (Kreindler et al., 2011) is located in western downtown core area. One of the other two referral sites is a tertiary care hospital located in the eastern core area of the city and the other is a community hospital in the west end of Winnipeg.

Study design

The purpose of this qualitative study is to explore how adult recipients of acute care surgery in the WRHA perceive the care provided to them in a consolidated ACSS program. A qualitative method was considered appropriate for analyzing patient experiences in a consolidated ACSS, as relatively little is known on this topic and in-depth understanding was desired.

Qualitative methods are well suited in areas where knowledge is scarce (Creswell, 2007), as is the case with consolidated ACSS. The main strength of qualitative research is that it generates data that offers depth and detail to create an understanding of events and lived experiences (Creswell, 2007). This method of research stimulates informants to actively think about the subject (Creswell, 2009). Data derived from qualitative studies are used to clarify experiences, improve understanding of a complex phenomenon, or shed light on participants' thoughts and feelings (Creswell, 2009). In this study, qualitative methods were used to explore how emergency surgical patients perceive their overall quality of care, access, communication, and safety in a consolidated ACSS program.

Theory/ Framework

The Appreciative Inquiry (AI) approach was considered as a framework in this study to capture rich data on patient experiences in a consolidated ACSS. I chose to include the AI approach because it looks at organizational issues, challenges, and concerns in a significantly different way. It focuses on learning from successes and building upon the best of what is in a program, rather than focusing on its problems. I also included the AI approach because storytelling is the primary means of discovering “what is best” by focusing on participants’ own positive experiences (Cooperrider & Whitney, 2005), which I believe is especially applicable in the context of learning from patient experiences.

Appreciative Inquiry (AI) has proven to be a valuable addition to evaluation study design. AI provides a better understanding of what was most meaningful about a program or organization and identifies ways to build on the best of what is in the program or organization (Hanson Smart & Mann, 2003; Dunlap, 2008). AI also helps participants to be honest, more open, and collaborative with the researcher and the research process (Tzavaras Catsambas & Webb, 2003), and generates much richer data in comparison to traditional problem-focused approaches (Jacobsgaard, 2003).

In this study, I did not use a complete AI method as described by AI practitioners. Instead, AI was incorporated in designing a semi-structured interview guide for face-to-face interviews, collecting and analyzing qualitative data, and writing up the findings. I mainly used the “discovery phase” of the AI process.

What is Appreciative Inquiry (AI)?

Appreciative Inquiry (AI) is “a worldview, a paradigm of thought and understanding that holds organizations to be affirmative systems created by humankind as solutions to problems; it

is a theory, a mindset, and an approach to analysis that leads to organizational learning and creativity” (Watkins & Cooperrider, 2000, p.6). Fundamentally, AI is a framework for thinking appreciatively with people about situations and settings (Watkins & Cooperrider, 2000).

Appreciative Inquiry (AI) is a positive, strength-based approach to organizational change with a specific focus on exploring and understanding what factors are in place when a program or organization is functioning at its best (Coghlan et al., 2003). AI selectively seeks to find, highlight, and illustrate the exciting “life-giving” forces in an organization. AI “looks for ways to do more of what already works” (Hammond & Royal., 2001, p. 234). AI involves the art and practice of asking questions; the questions are designed to look for the best in the organization, to look at its successes, to try to understand what makes successes happen in order to think of ways to extend and develop positive factors. This approach appreciates each participant’s unique experience, knowledge and feelings, and focuses on the importance of dialogue (Coghlan et al., 2003; Hammond & Royal., 2001).

Cooperrider and Whitney (1999) offer the following practice-oriented definition of AI:

Appreciative Inquiry is the cooperative search for the best in people, their organizations, and the world around them. It involves systematic discovery of what gives a system ‘life’ when it is most effective and capable in economic, ecological, and human terms. AI involves the art and practice of asking questions that strengthen a system’s capacity to heighten positive potential. It mobilizes inquiry through crafting an ‘unconditional positive question’ often involving hundreds or sometimes thousands of people (p. 10).

While Appreciative Inquiry (AI) focuses on identifying strengths and what gives “life” to organizations, it does not necessarily mean that everything is positive. AI does not ignore or deny problems. Rather, it shifts attention away from critical and pessimistic perceptions of the organization toward supportive and optimistic behaviors. Instead of looking for “what’s wrong” or “what needs to be fixed,” AI focuses on “what’s right” and “what’s working” and seeks to

carry out more of these positive actions. As Tom White, former president of GTE Telephone Operations, stated:

Appreciative Inquiry can get you much better results than seeking out and solving problems ... If you combine a negative culture with all the challenges we face today, it could be easy to convince ourselves that we have too many problems to overcome—to slip into a paralyzing sense of helplessness.

... Don't get me wrong. I'm not advocating mindless happy talk. Appreciative Inquiry is a complex science designed to make things better. We can't ignore problems—we just need to approach them from the other side (Cooperrider and Whitney, 1999, p. 8)

Appreciative Inquiry (AI) suggests that we can create change by paying attention to desired outcomes rather than paying attention to problems.

Principles and Assumptions of Appreciative Inquiry

Appreciative Inquiry (AI) principles are rooted in theories of social constructionism and the power of image to motivate organizational change. These principles serve as a foundation for understanding how AI is implemented and how it works (Cooperrider & Whitney, 2005). Five basic principles have been described as central to the theory of AI (Cooperrider & Whitney, 1999):

1. Constructionist principle
2. Principle of simultaneity
3. Poetic principle
4. Anticipatory principle
5. Positive principle

Constructionist principle: The constructionist principle holds that “human knowledge and organizational destiny are interwoven” (Cooperrider & Whitney, 1999, p. 25) and relates to the notion that multiple realities exist based on perceptions and shared understandings. Realities are

constructed through language and conversation, and individuals are considered as part of a social system.

Principle of simultaneity: The principle of simultaneity suggests that inquiry and change cannot be separated; they occur simultaneously. Change begins as soon as individuals ask questions and engage in a conversation. Therefore, the questions set the stage for what is discovered and provides inspiration for images of the future.

Poetic principle: The poetic principle states that “human organizations are like open books. An organization’s story is constantly being co-authored. Pasts, presents, and futures are endless sources of learning, inspiration, or interpretation.” (Cooperrider & Whitney, 1999, p. 26) Stories are open to multiple interpretations. An organization is like a narrative, an impressive story, which is co-authored by various stakeholders; the stakeholders are free to choose what they desire to study in the organization, its problems and needs, or its moments of creativity and joy. The choice of the inquiry influences the direction of the organization.

Anticipatory principle: The anticipatory principle contends that images of the future lead current behavior of any individual or organization, especially through an artful creation of positive imagery. If the future images are positive, affirmative, and hopeful, then the present day will be correspondingly more positive and productive.

Positive principle: The positive principle suggests that “momentum for change requires large amounts of positive affect and social bonding” (Cooperrider & Whitney, 1999, p. 27). Attitudes such as hope, enthusiasm, and inspiration, sense of urgency, and the joy of creating something meaningful with one another are essential to the positive principle. This principle arose from early experiences with AI; researchers realized that when more positive questions were asked, participants were more engaged and excited. The effort afforded to change was more successful

and long-lasting (Cooperrider & Whitney, 2005). In other words, people and organizations desire to strive toward positive images that give them energy, passion, and happiness and result in positive actions.

Based on these principles, eight assumptions shape the foundation of AI's processes and methods (Hammond, 1998, p. 20–21):

1. In every society, organization or group, something works.
2. What we focus on becomes our reality.
3. Reality is created in the moment, and there are multiple realities.
4. The art of asking questions of an organization or group influences the group in some way.
5. People have more confidence and comfort to journey to the future (the unknown) when they carry forward parts of the past (the known).
6. If we carry parts of the past forward, they should be what is best about the past.
7. It is important to value differences.
8. The language we use creates our reality.

The major assumption of AI is that in every organization something works well; change can be influenced through identifying what works and analyzing how to do more of what works; and asking questions initiates the process of change. AI assumes that organizations and individuals move toward what they focus on, and what they focus on becomes their reality. AI also assumes change is difficult and complex, but it will be much easier if the best of the past is brought forward with the change. AI presumes that differences should be valued; and the words we use to describe our reality essentially create that reality.

Appreciative Inquiry Process and Method

Appreciative Inquiry (AI) principles and assumptions come to life through the AI process. The AI process includes four frequent and sequential phases known as the “4-D cycle”. The 4-D cycle guides the AI process through the following four phases: the discovery phase appreciates

“what gives life,” the dream phase imagines “what might be,” the design phase determines “what should be,” and the destiny phase establishes “how to empower, learn, and adjust” (Cooperrider & Whitney, 1999, p. 11). The first step and foundation of the entire AI process is to identify an affirmative topic. The topic selection process leads to what gives life to an organization, and represents what the organization wants to discover or learn more about. The topic selection process involves conversations regarding the desired future and more of what the organization would like to see as a focus of development (Cooperrider et al., 2008). Following the selection of the affirmative topic, the 4-D cycle proceeds to the discovery phase.

The discovery phase explores participants’ positive narratives and experiences and involves several steps. The first step is to identify stakeholders and decide who should participate in appreciative interviews. Next, an interview guide is developed. As Cooperrider and Whitney (2005) mentioned, during development of the interview guide, we should remember that “what we ask determines what we find; what we find determines how we talk; how we talk determines how we imagine together; [and] how we imagine together determines what we achieve.” (Cooperrider et al., 2008, p. 325)

An appreciative interview guide contains an introduction to explain the purpose(s) of the project and the three parts of questions: stage-setting questions, affirmative topic questions, and conclusion questions. In the stage-setting, questions are developed to look for participants “peak experiences” and “what they value most.” Affirmative topic questions are positive questions about the topic or subject matter surrounding AI to look for the best in the past and the possibilities for the future. Closing questions conclude the interview and retain the sense of possibility by asking questions such as, “What three wishes do you have for changing the

organization?”(Cooperrider et al., 2008, p. 325) A positive, hopeful, and generative tone in questions is essential to the process of discovery (Cooperrider & Whitney, 2005).

The next steps involve organizing appreciative interviews and arranging who will conduct the interviews, determining how interviews should be recorded, and then carrying out the interviews. Storytelling and interviewing are the most important part of the discovery phase; participants interview each other and share their individual stories of positive experiences. Appreciative interviews are usually conducted in pairs, and each participant takes a turn at interviewing and being interviewed. Participants follow interview guide questions to describe their stories. They also probe deeper into the answers, show enthusiasm, and listen intently. The purpose of these steps in the discovery phase is to energize both the interviewers and interviewees, as they share their experiences with the organization and their values and wishes for the future. After the pair interviews, participants share their stories with a larger group and together identify key topics or “positive cores” which are common in all stories. Analyzing the stories provides a list of values and strengths prioritized by all participants. This highlights the factors identified that lead to success (Cooperrider & Whitney, 2005).

In this study, the researcher developed a semi-structured interview guide that included three types of questions: stage-setting questions, affirmative topic questions, and closing questions that sought to capture participants’ best stories and high-point experiences. The interview guide is attached to this document as Appendix A. The researcher conducted face-to-face interviews with all participants, and asked them to share their positive stories about their acute care surgical experiences, while she remained a neutral interviewer. The researcher analyzed all the stories, categorized data based on what participants valued most, what they identified as their best experiences, and what factors shaped these best experiences. These findings were then shared

with participants in a follow-up focus group interview in order to verify and validate the findings. The researcher mainly applied the discovery phase of the AI in this study.

The dream phase of the 4-D cycle, a continuation of the discovery phase, focuses on envisioning possibilities for a desirable future. During the dream phase, participants review the findings in small groups and discuss their individual visions of an ideal organization. Participants explore their hopes and probe their imaginations and wishes during this phase. Then, participants together begin to think broadly and holistically about this desirable future and formulate a plan for their organization. The outcome of the dream phase usually is a vision for a better organization (Cooperrider & Whitney, 2005). The dream moves towards the next step, which is the manifestation of the dream into reality.

The design phase, the third phase of the 4-D cycle, begins to construct a bridge from “the best of what is” within the organization toward “aspiration of what might be” (Cooperrider & Whitney, 1999, p. 15). During the design phase, participants “challenge the status quo as well as common assumptions underlying the organization’s design” (Cooperrider & Whitney, 1999, p. 15), and identify key aspects of organizational structure, and propose strategies, which are essential in creating the ideal system for the organization. They also develop “provocative propositions” that are affirmative statements of detailed visions of the ideal system and are based on past successes discovered in prior phases. In the design phase, participants collaboratively make decisions and develop plans to ensure that the dream becomes reality. In summary, “the design phase involves the collective construction of positive images of the organization’s future in terms of provocative propositions based on a chosen social architecture. These designs help move the system to positive action and intended results” (Cooperrider et al., 2008, p. 46)

The final phase of the 4-D cycle is the destiny phase. The destiny phase brings the organization back to the discovery phase. It involves continuous learning and adjustment of actions, through reviewing and communicating progress. In this phase, participants celebrate what they have achieved and learned thus far in the process. The destiny phase empowers individuals in the organization to connect, cooperate and co-create, and it results in new and innovative developments.

In summary, AI is a narrative based process of positive change. It consists of a cycle of activities that starts by engaging all members of an organization or community in a broad set of interviews and deep dialogue about its successes, strengths, and capabilities. It then moves people through a series of activities focused on envisioning possibilities and lifting up the most “life-giving” factors, while imagining a positive future. The process then involves people discussing and making plans for the future together. Finally, it involves the creation of groups to perform the plans, review progress, and realize a new dream and design for the future (Cooperrider & Whitney, 2005). It is important to remember:

No two Appreciative Inquiry processes are alike. Each is designed to address a unique strategic challenge faced by the organization Each is designed to optimize participation among stakeholders. This means that the four D’s of AI—discovery, dream, design and destiny— can take many forms of expression (Cooperrider & Whitney, 2005, p. 25).

Appreciative Inquiry (AI) has been used in different levels within organizations, from the whole organization to the department level, as well as in whole communities (Odell, 2000; Holman et al., 1998). AI is being introduced into the healthcare field and many international healthcare organizations have applied AI methods in their organizations to initiate positive changes (Wood, 2004; Reed & Turner, 2005; Williamson & Suchman, 2004; Havens et al., 2006; Reed et al., 2002; Hirunwat, 2011). For instance, the Lovelace Health System used AI

methods to create a “positive future for nursing.” Applying AI methods resulted in reducing nursing staff turnover and vacancy rates, increasing job and patient satisfaction as well as enhancing communication and relationships among nurses and other health professionals (Wood, 2004). In another study, AI methods were used to enhance satisfaction and engagement of elderly patients in a nursing home in Thailand and to increase business sustainability in the facility (Hirunwat, 2011). Reed and colleagues (2002) applied AI methods to optimize the process of hospital discharge. In another study, he and his colleague used AI to evaluate the process of change in a cancer services collaborative improvement project in the United Kingdom (Reed & Turner, 2005). Zakariasen and colleagues (2002) used AI to help dental teams create a vibrant new vision for their ideal practices for future. Furthermore, AI has been used to facilitate positive culture change in a medical school (Williamson & Suchman, 2004), and to enhance quality of nursing work and patient care (Havens et al., 2006).

Appreciative Inquiry (AI) researchers and practitioners indicated that applying AI as a philosophy, approach, or method in evaluation activities provides meaningful and useful results. AI achieves this through underlining affirmative and positive questions, following a structured process, considering inquiry as a continuous cycle, and highlighting the use of findings. Applying this approach also increases participant involvement in the evaluation (Coghlan et al., 2003).

Although only certain elements of the AI approach were applied in this study, an adapted AI approach still offers several benefits. One of these benefits concerns the kind of information that I received. Involving patients in a discussion about what was best in their acute surgical experiences and what made these experiences the “best” provided a better understanding of what was most meaningful to the patients regarding acute surgical services. The AI approach also

balanced collecting data through obtaining additional and different insights regarding what worked well and what could have worked better in the consolidated ACSS. Appreciatively worded questions proved to be effective in getting valuable data relevant to acute surgical program quality and participant experience. Beyond obtaining useful and meaningful data from participants, the AI approach helped to create a positive feeling in participants, while they were describing aspects of their experiences.

Data Collection Procedures

This research was conducted in the WRHA and involved patients who had acute surgery in any of three ACS sites: Health Sciences Centre, St. Boniface General Hospital, and Grace General Hospital.

A purposive sampling approach was used to ensure that participants reflected the diversity of types of acute care surgeries conducted in Winnipeg including recruitment from the different ACS sites in Winnipeg, and the perspectives of various genders and ages. Participants were patients who were aged 18 years and older, diagnosed with acute appendicitis, acute cholecystitis, or acute small bowel obstruction, and who received acute care surgery from one of the three ACS sites. The ability to read and speak English and stable mental and physical health status were other inclusion criteria.

Participant recruitment

Participants were recruited through a collaboration of surgical nursing staff at each ACS site and the researcher. First, the researcher met with the director of the WRHA surgery program and explained the purpose of study, inclusion criteria, recruitment plan, and the interview process. Next, the researcher asked for the surgical staff's assistance in identifying and informing eligible

participants of the study. The researcher requested a mixed sample of patients who either had to be transferred for an acute surgery or received acute surgery at the initial hospital site.

Surgical unit nurses at each ACS site identified patients who met the inclusion criteria and informed them about the study, while patients were still in the hospital recovering. Nursing staff used a written script to inform patients about the study and asked patients' permission to provide their names to the researcher in order to be given with more detailed information about the study. A copy of the recruitment instructions and script for surgical staff is attached as Appendix B. Nursing staff added the name of informed patients to a list to avoid patients being approached by multiple nurses. A poster including the purpose of the study, inclusion criteria, details on the interview process, and researcher contact information was distributed among the surgical nursing staff and displayed in the staff room and nursing station at each ACS site to facilitate the recruitment process (Appendix C).

The researcher was in contact with the nursing staff at each ACS site and made regular visits to the hospitals to meet interested patients and provide detailed information to potential participants. The researcher contacted potential participants seven to ten days after discharge since many surgical patients are able to resume their normal life activities one week after surgery (Barthelsson et al., 2003). For those potential participants who could not be reached within ten days, the researcher continued calling for an additional two weeks. Most interviews were conducted within ten days following the patient's discharge. A place and time for the interview was scheduled, based on the convenience of the participants.

Twenty-five patients were recruited by nursing staff from all three ACS sites. Twenty of these patients agreed to participate in the study; however, three participants were excluded as a result of a wrong diagnosis (one patient) or no surgery (two patients). One participant declined

since her daughter's wedding was fast approaching, and three participants could not be reached due to a wrong phone number (one patient), or no phone answer (two patients).

Data collection

Data collection took place through in-depth, face-to-face interviews with thirteen participants. The purpose of the interview was to identify participant views on their experiences through questions and interaction. "Interview and storytelling are preferred methods for gathering data because these methods make people get in touch with the human spirit and make them share from the heart." (Hammond & Royal., 2001, p. 264)

The researcher conducted all thirteen interviews from August to October 2010. Interviews were conducted until points of data saturation were reached. Data saturation occurs when the researcher is no longer hearing or seeing new information (Creswell, 2007). The duration of the interviews varied for each participant and ranged in length from 28 minutes to 70 minutes. The interviews were audio-taped and later transcribed verbatim by the researcher. Employing this method increased the eye contact between interviewer and interviewees and allowed the interviewer to pay full attention to the participant's stories and experiences. All information gathered in this study including transcripts and consent forms are being kept in a locked filing cabinet at the WRHA and will be kept for seven years, at which time they will be destroyed and treated as confidential waste. A copy of the informed consent form for individual interviews is attached as Appendix D.

A semi-structured interview guide, derived from the AI approach, was used to allow for free-flowing discussion, while ensuring that all areas of interest were covered and to generate rich data from the interviews. In order to follow-up responses and to encourage participants to give more detailed answers to open-ended questions, the interviewer probed deeper into participants'

initial responses by asking questions such as ‘could you tell me more about that?’ and ‘what do you mean?’

In addition, field notes were taken by the researcher in order to record observations, behaviors, and activities during the interviews. These notes included what the researcher hears, sees, experiences, and thinks in the course of collecting and reflecting on the process (Liamputtong, 2009). The researcher also wrote observational notes immediately following each interview.

The participants were also asked for demographic information such as the type of surgery they experienced, their age, ACS site, and level of education. This demographic information was collected to describe the characteristics of the sample. A copy of the demographic information collection sheet is attached as Appendix E.

Data Analysis

An ongoing data analysis was performed along with the data collection. The data from interview transcripts and field notes were analyzed separately line-by-line. The transcripts were typed using Microsoft Word. One hard copy and two digital copies of each transcript were made. The researcher read and highlighted “segment of information” or codes on the hard copy (Creswell, 2009), then used “Insert Comment” in Microsoft Word to add notes to the identified highlights. One digital copy was excluded from this process and remained intact as an original transcript. Transcription was conducted in the sequence in which the interviews took place.

The process of data analysis involved listening to tapes, transcribing the records, reading the entire transcripts several times, and reading the field notes taken during and following the interviews. The aim was to get a sense of the interview(s) as a whole and obtain details before constructing parts (Creswell, 2009).

The researcher identified one hundred and two codes or “segments of information” from all interview transcripts. During this process, major themes began to emerge. Next, ideas and concepts from the texts were put together and categories were formed. The researcher inputted the codes into an Excel sheet and categorized them into different categories by various colors; twenty five categories were identified, several of which overlapped. The researcher then reviewed the original transcripts and sought to reduce the number of overlapping categories. Ten themes, with at least two sub-categories, emerged in preliminary analysis. By continuing revisions, reviewing transcripts, looking at field notes, and comparing themes, eight themes emerged. The last phase involved the researcher highlighting and sorting out quotes.

During the process of analyzing data- identifying codes, creating categories and themes, sorting out quotes- the researcher followed the AI approach in answering questions such as: what was working, what was the best experience, what participants valued most, what factors shaped the best experience, and what were their wishes for the future. Following preliminary data analysis, the researcher reflected on all findings and asked herself the following questions:

- What themes or incidents in the data capture the “best of the best” of participant experiences?
- What does the system and the individuals who provide patient care need to do more of? (Build on what is working well).
- What would ideal patient care look like? What needs to happen to create this ideal experience?

Answering these questions helped to distill the main themes from a longer list and organize the presentation of the findings.

Trustworthiness

Four factors are considered in establishing the trustworthiness of findings in qualitative research: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985).

Credibility refers to the confidence one has in accuracy of the findings and can be accomplished through various strategies such as prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis, and member checks (Lincoln & Guba, 1985). In my research, I employed member checking as well as peer debriefing. Member checking is one of the most important strategies for enhancing the credibility of a qualitative study and involves sharing interview transcripts, interpretation, and/or findings with study participants, in order to determine if the study conclusions reflect their own perspectives (Lincoln & Guba, 1985). Accordingly, in my study, member checking was conducted through a follow-up focus group interview with two study participants after the preliminary analysis. In the follow-up focus group interview, the preliminary findings and themes which emerged during the individual interviews were presented to the study participants and they were asked in which way these findings were similar or different from their own experience. Participants in the follow-up focus group interview confirmed that the findings described their stories and captured all aspects of their experience. Since three out of five participants who agreed to participate in the follow-up focus group interview were not able to attend, some phone calls were made to obtain feedback and verification from absent participants. The researcher was able to conduct a phone interview with only one additional participant.

Peer debriefing, as an “external check of the research process” (Creswell, 2007; p 208), contributes to the rigor of a study by keeping the researcher sharp and true (Lincoln & Guba, 1985). A peer debriefer is an individual who keeps the researcher honest, listens sympathetically to the researcher’s concerns and thoughts, and asks questions about meaning and interpretations (Creswell, 2007). Peer debriefing occurred informally during this study through discussions with friends, colleagues, and members of the researcher’s thesis advisory committee. In particular, a

friend who is a PhD student in the department of Community Health Sciences became the researcher's peer debriefer for most of the study's duration. She provided great support during the process of data collection and analysis; her feedback and emotional support kept me devoted to the project and reduced my personal bias.

An important factor in increasing the rigor of a qualitative study is transferability. Transferability refers to the ability of applying the findings of the study in other contexts. Transferability can be improved by describing the research context and its assumptions in logical order (Lincoln & Guba, 1985). To enhance transferability, I presented the findings with rich and thick descriptions of participant experiences. Furthermore, the WRHA surgical program and various aspects of consolidated ACSS have been explained in detail.

Dependability refers to the stability and constancy of the findings over time, and confirmability refers to the degree to which the findings could be confirmed or corroborated by others (Lincoln & Guba, 1985). To address the issues of dependability and confirmability in my study, one of my thesis advisory committee members who is a professor in the faculty of nursing and has considerable experience in conducting and analyzing qualitative data (S.McC), read and coded the transcripts independently with an aim of comparing her findings with mine. That process showed that both of us were in agreement about the recurrent themes arising from the interview data. In addition, following the initial recording of findings, feedback was sought from my thesis advisory committee members. The committee members were also asked to comment on whether my interpretations were meaningful to them.

A verbatim record of the interview is a key contributor to the quality of data analysis (Poland, 2001). The researcher transcribed all interviews verbatim by listening to audio-records several times and putting them into a written text. The researcher also tried to capture nonverbal

cues such as body language and silence, and emotional aspects like coughs and sighs. Having the researcher transcribe the interviews directly, provided the following advantages: the researcher was brought closer to the data; it gave her first-hand information, and facilitated data analysis (Poland, 2001). However, the process of transcribing is open to a range of human errors including: missing words, misinterpreting words, and making language errors, particularly as English is not the researcher's first language. To increase the quality of data, the researcher asked the peer debriefer to review the transcripts as well.

The literature review was not completed until the analysis of data was concluded. A cursory review of the literature helped to ensure that the study findings were not adapted from existing themes in the literature and further assisted enhancing in the rigor of the study's findings.

Ethical Considerations

Research ethics approval was obtained from the University of Manitoba's Health Research Ethics Board of the Faculty of Medicine and the Research Review Committee of the WRHA in July 2010. The approval included an evaluation of the research proposal, recruitment instructions and script for surgical staff, poster, demographic information sheet, participant consent forms, and the semi-structured interview guide for both individual interviews and the follow-up focus group interview.

All participants in this study were fully informed about the purpose of study. They were also informed that their participation was voluntary and their decision to participate or not participate in the research study would not affect the level of services they receive from the WRHA. They were informed they could withdraw at any time during the study. The process of the interview, including its place and duration, and the consent form were described to each participant prior to engaging in data collection.

Written, informed consent was obtained from each participant at the beginning of the interview, and confidentiality was maintained. All identifying information from the interview transcripts was removed from the data, and each participant was assigned a unique code. This code was used to attribute comments during the analysis.

Limitations

This study has a number of limitations. Since participation was voluntary, potential self-selection bias was unavoidable. Representation from all different types of acute care surgeries at each ACS site was not possible. The findings of this study are limited to patients who had surgery during the participant selection and data collection period.

The qualitative approach and non-probability sampling limit generalizability of the findings. The sample also consisted of all English speaking people, thus the experiences of non-English speakers was not captured.

CHAPTER FOUR: FINDINGS

Introduction

This chapter has been divided into two sections: characteristics of participants and participant responses. The first section, characteristics of participants, illustrates participants' demographic information such as age, gender, level of education, and their surgical diagnosis as well as information regarding face-to-face individual interviews including interview duration and location.

The next section, participant responses, is further sub-divided into three parts: part one describes the overall experiences of both transferred and non-transferred patients and explores factors that affected their surgical experiences. Part two addresses transferred patients' perceptions of consolidated acute surgical services, and explains factors specifically affecting their experiences in the ACSS model. The final section highlights opportunities for improvement from participants' points of view. A summary of major themes described in parts one and two is shown in Table 1.

Throughout this chapter participant quotes and case scenarios have been used to illustrate the findings. Quotes are taken directly from interview transcripts; changes have been made for the purposes of clarity and to protect the identity of participants.

Table 1- Summary of major themes

<i>Themes</i>	<i>Categories</i>	<i>Sub-categories</i>
Clear and effective communication	Good-bedside manner	Nursing staff bedside manner Doctor bedside manner
	Doctor-patient relationship	
	Nurse-patient communication	
	Provision of timely & sufficient information	
Excellent nursing care	Treating patient with compassion & respect	
	Responding to patient need quickly	
	Facilitating patient physical comfort	Anxiety Pain management Hospital environment
Timely access to surgical services	Length of waiting time in ER	
	Availability of diagnostic services	
Continuity of patient care	Interpersonal continuity	
	Informational continuity	
Patient safety	Potential medication error	
	Post-operative adverse event	
Transfer to an ACS site	Waiting to be transferred	
	Condition of road	
	Difficulty of patient family	
	Risk involved in transfer	
Communication regarding the transportation to an ACS site	Informing patient regarding the transfer	
	Communicating with ambulance staff	
Process of admission to an ACS site	Quick & smooth admission	
	Time-consuming admission	

Characteristics of Participants

This study was been conducted within the Winnipeg Regional Health Authority (WRHA) and involved patients who were diagnosed with acute appendicitis, acute cholecystitis, or acute small bowel obstruction and who had an emergency surgery in any of three Acute Care Surgical (ACS) sites. Thirteen participants were interviewed including seven women and six men; their ages ranged from 23 years to 81 years, with a mean age of 48 (SD= 16).

Most interviews took place in participant's homes and four interviews took place at an office at the WRHA. The average interview duration was 46 minutes, ranging from 28 minutes to 70 minutes. The longest interview, 70 minutes, was conducted with a fifty-two year old woman. In addition to describing her recent surgical experience, this participant discussed her previous experience in the emergency room coping with the same problem and symptoms six months prior to her surgery.

Seven of the participants underwent surgery for cholecystectomy, four for appendectomy, and two for a small bowel obstruction. The level of education varied among participants: five participants had a high school diploma, five had some college education, and two held a bachelor's degree. A majority of participants (eight participants) were recruited from one of the ACS sites. Demographic characteristics of participants are presented in Table 2.

Table 2- Demographic Characteristics of Participants

Participants	Age (in years)	Interview Duration (minutes)	Interview Place	Diagnosis	ACS Site	Level of Education
F	53	61'	Home	Cholecystitis	A	HSD
F	23	50'	Home	Cholecystitis	A	HSD
M	47	46'	Home	Cholecystitis	A	SC
F	35	45'	Home	Appendicitis	A	LHSD
F	52	70'	Home	Cholecystitis	B	SC
M	81	28'	Home	Cholecystitis	A	SC
F	53	37'	Home	Cholecystitis	B	HSD
M	60	45'	Home	SBO	B	HSD
M	64	40'	Home	Cholecystitis	A	SC
F	52	40'	Office	Appendicitis	A	SC
F	28	35'	Office	Appendicitis	A	B
M	35	45'	Office	SBO	C	HSD
M	41	50'	Office	Cholecystitis	B	B

F: Female **M:** Male

Home: Participant Home

Office: WRHA Office

SBO: Small Bowel Obstruction

ACS site: Hospital **A**, Hospital **B**,

Hospital **C**

LHSD: Less than a High School Diploma;

HSD: High School Diploma; **SC:** Some

College; **B:** Bachelor Degree.

Participant Responses

Participants in this study described their experiences regarding their acute care surgery within a consolidated acute care surgical services (ACSS) in the WRHA and identified what they valued most about the surgical services that they received from the acute care surgical (ACS) sites and emergency department.

An overall view of all participant experiences in a consolidated ACSS

This section provides an overview of all participant experiences within the consolidated ACSS and identifies factors that appeared to affect participants' perceptions of their experiences. Participants were asked to share stories of their acute care surgery including both those that they perceived had gone very well and those with which they were less satisfied. The following findings are based on analysis of these data.

Almost all participants in this study (11 out of 13) expressed satisfaction with the care and services they received from the ACS sites, describing mainly positive experiences. Several participants described their overall experiences as “good” based on the care provided by the nursing staff in an ACS site. Four participants emphasized the entire experience in a hospital related to nursing staff and the care provided by them.

“The entire experience of the hospital depends on nursing staff; I believe that, doctors don’t have a lot to do with patients except surgery, so you depend on the nursing staff.”

(53 year old woman- A)

A number of participants described their experience as “good” since they did not have any “problems” or “complaints.”

“It was pretty good actually. ..., never got a problem during and after; so, I think it went good.”

(23 year old woman)

However, two participants expressed different sentiments. The description of their experiences indicated that, overall, they were not satisfied with the surgical care they received and described mainly negative experiences. One participant stated considerable frustration and concern regarding the diagnostic process and the delayed communication in that regard.

“Overall, I was frustrated by the, um, from surgical perspective, from the surgeon’s perspective I was frustrated; from diagnosis perspective I was frustrated ... just from diagnosis and the actual dealing with the surgeons I was quite frustrated really... It took quite a long time for them to get diagnosis, and there was quite a bit of the lengthy period of time where I didn’t know what is going on.”

(47 year old man)

Another participant described her overall experience as “a four, four out of ten”. Her story demonstrated that she was dissatisfied with the post-operative care provided to her, the lack of clear and sufficient communication regarding her medical situation, and delays in provision of care. These experiences led her to rate her overall experience as poor.

“I went to the hospital [A] around 8:30 in the morning on Sunday and my operation was about 8 o’clock at night [at hospital B][short pause], and then I was fine for that day after, and all of a sudden I couldn’t breathe and nobody really told me what happened; if it was infection that it goes into my lungs, if it was something else, nobody really told me [pause] what went wrong; [pause, then giggled]; so, I don’t know, I don’t know if that’s the best experience or not; I wasn’t in any much pain except for that one that I couldn’t breathe, I was just gasping for the air; but it was just kind of amazed me that it took 14 hours for them to really do something because I think I wouldn’t have gone that bad if something would happen faster, from the X-ray at 11:30 at night to 14 hours later I don’t know if anybody looked at the X-ray or they looked at and thought, oh, well; I don’t know; I went through the whole night 14 hours of, it wasn’t almost until 2 o’clock the next day that they took me into the intensive care [Pause & giggled]... I think it could have been handled a lot better.”

(53 year old woman-B)

Participant stories of their acute care surgery indicated that their perceptions of their acute care surgical experience and their overall satisfaction is not based only on their recent experience, but is also dependant on previous experiences within the healthcare system. This suggests that patients’ previous experiences in the healthcare system might shape their overall

assumptions of quality of care and affect their perceptions and expectations. An eighty-one year old participant compared the care provided at the ACS site with the care he received in the emergency room “I was well cared for and probably better than in the emergency.” Another participant contrasted her recent experience with a previous experience at the same hospital and referred to the care provided to her this time as timely.

“At the ... hospital they were very good! I had another experiences there and I haven’t ever liked the ... hospital; but I was very happy this time around and I like [it]; they took me quickly, they took care of the situation ...”

(53 year old woman-A)

A sixty year old man expressed his confidence and satisfaction with an ACS based on his previous good experience at the same hospital.

“I had an experience before because of triple bypass surgery at the same hospital; they look after you good I think so... [I value most] their care; most of them, they care and they did the right thing on time; [I] didn’t have any complications.”

(60 year old man)

Furthermore, a twenty-eight year old woman described her surgical experience as “amazing” in comparison with her prior surgical experience.

“Overall, I think it was amazing like I had surgery before on the past and the nurses and doctors and staff were awesome.”

(28 year old woman)

One participant expressed that his acute care surgery was his first encounter in a hospital setting and extended his good experience to the entire healthcare system.

“It was good ... no concern. It served my needs; ... the need arose and then I got a good care and they seem to fix the problem and we are very fortune to have a healthcare system like we do; I didn’t realize that until in that situation ... it was actually my first encounter; I value that they were able to solve the problem, fix the problem.”

(64 year old man)

In the follow-up focus group, a fifty-two year old woman emphasized how her recent surgical experience ranked as “excellent” in comparison to her previous experiences in the emergency room related to the same medical issue.

“...I would say generally my experience was positive; but I can definitely, definitely relate to the gentleman because this is I had been in a situation earlier in the year and if you would had asked me then I say I couldn’t have anything positive to say about the healthcare system period I was in ... I basically went in [ER] knowing what was wrong with me because I’ve been experiencing this problem for months on end and it was just the basically question of once it gets bad enough then we’ll do something about it, so it was basically I’d have an attack, I come in, I wait, they do some blood work, ‘No, not bad enough, go home;’ so it was kind of like [pause] a hit-or-miss and that part was very frustrating and um, yeah, it, I mean if I had not good support at home I say I think [pause] I could have probably been a lot angrier, frustrated; by the time I did get in and had my surgery done I say, um, yeah, things were generally better.”

(52 year old woman-A)

Factors affecting patient experiences

Based on analysis of participant stories and responses to a question about what they valued most about the acute care surgical services, the following factors appeared to affect patient experience and perceptions of quality care provided in an ACS site:

- Clear and effective communication
- Excellent nursing care
- Timely access to surgical services
- Continuity of patient care
- Patient safety

Participants’ experiences relevant to each of these factors will now be presented.

Clear and effective communication

All participants in this study (N=13) emphasized that providing clear and effective communication is a core clinical function in emergency surgical services and has a substantive role in patient experience. Participant stories illustrated clear and effective communication as

being a two-way verbal communication that is transparent, understandable, and empathic. Clear and effective communication is particularly pertinent in an emergency situation where patients experience care in a chaotic environment without any previously established doctor-patient relationship.

In spite of acknowledging the importance of communication, participants had different experiences. Some patients appreciated the clear and effective communications they experienced; whereas, others felt that healthcare professionals, including emergency room doctors, surgeons, and nurses, were not able to communicate effectively. A fifty-two year old woman expressed her appreciation of clear and effective communication provided by healthcare professionals this way:

“I value most the communication that they provide to the patients ..., you know, telling you what’s going to be happening ... [I value] the communication with the patients.”

(52 year old woman-A)

Two participants expressed that they were delighted with the clear and effective communication they experienced and described they were not “left in the dark” and all their questions “were answered.”

“Everybody was very good; you know, there was no question left in our mind of when it is going to happen, what was going to happen, how long it’s going to take, I mean all of our questions were answered.”

(35 year old woman)

In contrast, two participants expressed their frustration with the lack of clear and effective communication throughout the entire process of their acute care surgery. Their stories indicated that lack of timely and clear communication led to psychological distress for them and their family. A forty-seven year old man described:

“Generally, the thing that could have been improved was certainly the communication, the explanation to me what was going on with me, with my care;

[timely and clear communication] was very lacking throughout the whole process really.”

(47 year old man)

Some participants (4 out of 13) highlighted the way doctors/surgeons communicated with their family members and mentioned clear and effective communication between doctor and family member resulted in patients and their families feeling less stressed and more reassured. One participant mentioned how well surgeons communicated with his family, explaining the procedure and duration of the operation, and informing family members why the surgery was prolonged.

“I think they did a very good job of that [communication]; they did communicate with the family what was happening, with the people that they’re supposed to, and I don’t have really that much of that; I thought they did well, told me when I was going to the surgery and gave them estimated time when I might be coming out; turned out my surgery was a little bit more complicated than they expected, so that took 2 hours longer than they thought; but the communication I thought was very good ... I thought it was very positive ... Everybody felt that they were in the loop sort to speak and it was great because everybody knew what is going on, and the family, and yeah, as I said that was really good. It’s a good way to treat, um, to treat the people like I was there and the family knows what’s going happening.”

(41 year old man)

Another participant described how her family members were anxious about the result of surgery and that good and clear communication with a surgeon helped alleviate their anxiety.

“I was actually told from my mother he [the surgeon] called up to the room and normally, you know, just from family having surgeries when the doctor calls up either at the end of surgery usually it is not so good news; so my father was a little apprehensive like taking the call, and he [the surgeon] explained the surgery went well which was good news.”

(28 year old woman)

In contrast, one participant reported that staff communication with her family members was not sufficient and clear, and resulted in greater anxiety and concern for the family members.

“... and they were telling my family not too much of what was happening... they scared the family quite a bit without telling them more what was going on, I mean,

had I been one waiting for somebody I think I would have been asking a lot more questions and go to the bottom of what's going on."

(53 year old woman-B)

Participant stories of their experiences demonstrated that effective and clear communication makes patients feel more comfortable and trusting of staff, and influences their overall positive experience with the surgical services. For instance, a sixty-year old man's story highlighted that clear and effective communication between doctor and patient instilled trust in the patient and increased his sense of ease and confidence in the procedure.

"...as long as I am in the hospital and the doctor tells me don't worry, we look after you, then you know they are there and nothing is going to happen..."

(60 year old man)

Another participant, a sixty-four year old man, described how he felt more comfortable as a result of a "good communication."

"The best communication was, um, I think once they discovered what was the matter everything was communicated to me, what they are going to do, yeah; it was a good communication, the doctor came to see me, actually to see I'm doing ok, ... they were very good, let me know what they were going to do and what was going to happen, oh, yeah, make you feel comfortable."

(64 year old man)

Clear and effective communication emerged as a major theme from the interviews with participants in this study as they spoke of four important issues:

- Bedside manner
- Doctor-patient relationship
- Communication with nursing staff
- Provision of timely and sufficient information

- **Bedside manner**

A majority of participants (9 out of 13) highlighted the way that healthcare professionals interact and communicate with patients and indicated the important role of staff behavior in their experience and perception of overall quality of care. Participants in this study appreciated a

good-bedside manner from healthcare professionals including emergency room doctors, surgeons, anesthesiologists, and nursing staff.

Nursing Staff Bedside Manner

A nurse's bedside manner refers to how a patient is effectively handled by a nurse and includes a nurse's attitude, tone of voice, and body language while treating patients and providing essential services. For example, a fifty-two year old woman described:

"... the first night when I was admitted, the nurse who admitted me on the ward was very forthright, she came up to me, you know, welcomed me ..."

(52 year old woman-B)

Another participant, a thirty-five year old woman, expressed the way a nurse greeted her as an important part of nursing staff bedside manner.

"The new nurse that, you know, came in and introduced himself that he was going to be my nurse."

(35 year old woman)

Although participants in this study did not directly refer to the term "nursing staff's bedside manner," several (5 out of 13) participants stated that the nursing staff demonstrated friendly and welcoming behavior in their interactions with them. This created a positive environment for receiving care and services. They described nursing staff as "compassionate", "very forthright", "kind", "friendly", and "understanding."

" Years ago, I've been in the hospital for other things and I haven't always found that nurses are very compassionate or friendly in the past that was I've noticed; um, all the nurses that were in there this time around they were all very compassionate, they were friendly ..."

(53 year old woman-A)

On the other hand, one participant reported a different experience. She perceived less welcoming interactions from at least some of the nursing staff and commented the nursing staff did not present a good bedside manner as a result of being tired, or "burned out." Her description

showed how lack of a good bedside manner might lead to frustration and a negative experience of nursing care delivery. She also highlighted “different personalities” among nursing staff.

“I had really good nurses and some that weren’t so good; it’s just personality, right; everybody does get different personality; the nurses aren’t the same; some of them are doing their job for too long, they just [pause]; some care lot more for the people than others do; and some because they are tired or they burned out or whatever.”

(53 year old woman-B)

Doctor Bedside Manner

Study participants described good physician bedside manner as greeting patients in a way that they feel comfortable, having a good communication style, willing to answer questions, spending sufficient time with patients and their family, and showing compassion in their tone of voice. A number of patients (3 out of 13) appreciated the good-bedside manner that they experienced from emergency room doctors and surgeons. A fifty-three year old woman described:

“...the doctor did make a point of introducing him to me before the surgery; even I never met him before because I had gone in and on the emergency, into the emergency room; so, I’d never met the surgeon and he did introduce him to me which I thought was good because it gives you a level of comfort before the start.”

(53 year old woman-A)

A thirty-five year old woman highlighted the way emergency room doctors and surgeons interacted with her family and appreciated their good bedside manner.

“I have to say when I was in pre-op, my husband and my mom were both there and they had questions as well, ... and the surgeons and the doctors were never ever rude, they explained the same things that they explained to me; so everything was really well laid out, very kind; it wasn’t just, you know, very sharp, rude answers, you know, like I got to go, I’m on my way; yeah, that was a good experience.”

(35 year old woman)

Some participants (3) highlighted how an anesthesiologist’s interaction and behavior made them feel calm and less stressed and appreciated the anesthesiologist’s openness to communication. For instance, a forty-seven year old man described:

“...they took me down to the surgical area, um, the anesthesiologist was there, so I chatted with him, he was very nice, he changed my IV and he talked, kind of talked a little bit, that was good ... and again, anesthesiologist was talking to me, gave me the mask and you know all of that and put me to sleep; and that was all fine, that all was good.”

(47 year old man)

The importance of doctor/surgeon’s communication style, in terms of attitude and tone of voice was highlighted by two participants as an influential factor in their perception of the quality of a doctor’s bedside manner. A twenty-eight year old woman described that she was not happy with the way a surgeon spoke to her, the surgeon’s tone of voice and his attitude.

“I had a doctor who came in and he was an on-call emergency surgeon, and he said he would be doing the surgery or another gentleman would be doing my surgery depending on what time they could get me at; and I would ask him questions about the surgery ... I thought he was a little bit rude, he didn’t have a good bedside manner, he wasn’t as nice as I thought he should have been especially with me, I’m a nurse, but I’m scared, this is happening to me, and I had some questions and he kind of cut me off in front of my family too which it wasn’t nice, just it didn’t leave a pleasant feeling when he left. And the other doctor that actually happened to do my surgery that was fine, he introduced himself before, I felt [giggle] a little bit more reassured ... just some of things he [first surgeon] said that I wasn’t too happy with like his attitude and his tone.”

(28 year old woman)

Another participant felt the surgeon did not spend sufficient time explaining his situation and did not consider his emotional stress.

“...you know, that conversation I felt was reasonable; well, it was a lot better that previous night conversation where the surgeon just came in and then within 30 seconds, you know, rattled off all the risks and then left; you know, at least on the second day, there was a little bit more of explanation, it was a little bit more ok, you know, they explained I mean that I had or it’s infected, um, the gallbladder, and so far; there was a little bit of more explanation and bit more of [time].”

(47 year old man)

Participants’ descriptions showed how small things such as a welcoming, greeting, and being open to two-way communication have a considerable impact on patient experience. They also

confirm that a good bedside manner is the first step toward developing a successful doctor-patient relationship, along with a clear explanation regarding the treatment.

- **Doctor-patient relationship**

The role of clear communication in building an effective relationship between doctor and patient was stated by all (N=13) study participants. A good relationship between doctor and patient was shaped by how well doctors/surgeons explained to patients what they were doing, whether they used words that were easy to understand, and the degree to which they felt they had been involved in their treatment decision. The following comment illustrates a good doctor-patient relationship as a result of clear and effective communication:

“I value that, um, the actual doctor and surgeon who both came in and spoke with me about the procedure and explained what’s going to happen and that if it didn’t end up being able to be, um, laparoscopic surgery, um, that it would be, you know, a full out surgery where they wouldn’t be able to use the laser; so, um, yeah, I really appreciated that; I guess that would be the most important part. I valued that the doctor and surgeon both came in to speak with me.”

(35 year old woman)

A fifty-two year old woman perceived that she had been involved in her treatment decision as a result of a good doctor-patient relationship and described:

“It was kind of situation that I mean I asked them for and he [doctor] was able to provide ... you are kind of taking charge of your own situation ... I mean this time just seemed to be more involved in my care, they [explained], you know, these are the tests we are going to do, sending you for, this was what they were looking for, um, just seemed to be a better flow of what was happening.”

(52 year old woman-A)

Another participant expressed that she did not completely understand the surgeon’s explanations of the surgical procedures and relied on nursing staff for a clear and understandable explanation.

“...I shouldn’t even say the doctor, because the doctor did speak a little over my head, and I would have got the nurses to kind of explain what he was saying...the

doctors do speak a little bit over your head [giggled]... Communication between myself and the doctor wasn't that good; um, he would have tried to describe what he was going to do, but he didn't describe it in enough detail for me to completely understand; um, so, I did speak to a nurse one time and told her I didn't quite get what he would have been saying and she tried to describe it better to me."

(53 year old woman-A)

A surgeons' inability to explain surgical procedure, in a way that allowed a patient to understand complicated medical terminology resulted in a breakdown in the doctor-patient relationship. However, the fifty-three year old woman did not criticize the surgeon for not being able to communicate clearly and laid the blame on the surgeon being "busy" and not having enough "time to explain clearly." She expected nursing staff to translate and clarify the surgeon's communication regarding the surgical procedure.

"I guess with the doctor, you kind of just accept that they are really busy and they can't take whole lots of time to explain things clearly. I think it's something we naturally accept [pause] and then kind of count on, hopefully the nurses would know [giggled] and they can tell you more. One nurse said to me 'I SPEAK ENGLISH' [giggled, laughed] because doctor is maybe a little bit, you know, the big words, [giggled] that we don't get [giggled]"

(53 year old woman-A)

One participant stated that she understood the surgeon's explanation regarding her surgical procedure. However, she did not perceive it as a two-way conversation and stated "the doctor informed me what he was going to do" and "there wasn't a lot of communication."

"Best communication was just the doctor informed me what he was going to do, um, nobody else was there, ... so, I guess any information was reread to me and there really, there wasn't a lot of communicating. Once the doctor confirmed that, I was wheeled to the surgery [room] and I remember that, and that was the doctor explained what he was going to do, and he said in the event that they can't do it, um, he said if we can't do it laparoscopically then I'm going to do incision on the right either like this [X] or this [+]"

(52 year old woman-B)

In contrast, a twenty-eight year old participant who is a nurse described that the surgeon provided a clear explanation of the surgical procedures, regardless of his poor bedside manner.

“I would say even though I wasn’t happy with the way doctor spoke to me, his attitude and his tone, he did explain both types of the surgeries as well; so, he spoke on behalf of himself the way he would do it, and also the other emergency room doctor, and he did answer all my questions that I had; it was just his tone and some of the answers he gave me when I was asking some questions, but he did, he did inform me at that time and kind of reassured me a bit what I’m going through, on my end as a patient not as a nurse.”

(28 year old woman)

- **Nurse-patient communication**

Effective communication with patients is an essential aspect of delivering nursing care (Williams & Gossett, 2001). Although most study participants expressed appreciation with the care provided by nursing staff, four patients (4 out of 13) specifically highlighted nurse-patient communication. Patients identified that effective nurse-patient communication is not only providing information, but also transmitting, recognizing, and acknowledging patient feelings. Participants in this study appreciated nursing staff’s verbal and non-verbal communication. The verbal component of nurse-patient communication mostly involved providing of information regarding the entire process of acute care and non-verbal communication included emotional supports provided by nursing staff. Patients described optimal nurse-patient communications as clear, understandable, and helpful which made them feel “confident” and secure.

“They [nursing staff] described what was going to happen ... very well; um, what would be happening in the hospital they described it well; ... I felt pretty confident.”

(53 year old woman-A)

“The one I was happy with, um, she was just, she was very thrilled on all examinations and she came regularly, she explained everything to me ...”

(52 year old woman-B)

One participant’s story indicated that a nurse established an atmosphere that invited her to show her anxious feelings and presented an emotionally supportive and caring behavior. This way of communicating exceeded the patient’s expectations and she described it as “the crowning moment.”

“I had my surgery on Thursday afternoon and then Friday evening I was up about walking ...now just was the question of getting well. I tend to get a little emotional, I’m just a very emotional person; so I was walking up and down on the hall and I was in front of nursing station and I guess I might have a look on my face, one of the nurses, her name was ..., she wasn’t even my nurse at that day I say, just saw me and said ‘oh, it looks like you need a hug’ [giggled] and I mean it was so cute; normally when you hug a person you grab them in front of you, kind of put your arm around her, and she just instantly knew I had a surgery you know, she just grabbed me from the side and sort of hugged my shoulder and held and I just thought ok,... but I say it was kind of, she just seemed to sense that, there was nothing physically wrong with me and I was under good pain control, I had you know family visiting me, it was just kind of like you know you just need sort of, um, and she just gave me a hug and [giggled]I just thought that was sort of the crowning moment I say, I mean I had excellent care and everything, but that was something that it was done sort of above and beyond.”

(52 year old woman-A)

The patient also emphasized that effective communication with nursing staff during pre-operative care not only provides patients with a level of comfort and safety, but also provides an important opportunity for a therapeutic interpersonal relationship to develop between nurse and patient. For instance, a fifty-two year old woman described:

“The nursing staff was very informative, um, they answered my questions very well... the nurses provided me with general information ... I found it very comforting ... I mean she was settling me into the bed, taking my blood pressure, my vitals ...[she] explained to me the process ... she said I know there is a lot for you to take in but sometimes she said it is sometimes better if you know what is going to be happening; I say you are better prepared ... she said whether you decide to go for walks or, whatever, I say you can kind of plan your day and be more prepared.”

(52 year old woman-A)

Another participant, a fifty-three year old woman, identified that nursing staff advocated for her by speaking with a doctor on her behalf. Descriptions of her experience indicated that she was happy and felt supported by the nurse.

“...the nurse working to prepare you, she explained what they are going to do ... I was really afraid because of you know ... I was really scared ... this woman [nurse] in that room, she didn’t look like a nice lady at all, and she turned out to be so nice, um, like, she was really nice to me, and she when the doctor came, asked him if he could give a little bit of this drug before I went to the room because I was so nervous,

and that helped me to be able to not panic [giggled], um, she was very good and I think that she just made me more comfortable."

(53 year old woman-A)

Two participants, however, perceived that nursing staff did not communicate with them in an active manner, and discussed how there was not "that much of communication" from the nursing staff.

"From the nursing staff, um, from them there wasn't really that much of communication; it was mostly actions from them like there wasn't a whole discussion really with the nursing staff ... they were the ones who were doing the stuff, they weren't really explaining that much, um, so, I don't know, I can't really think of any specific example from nursing perspective for the communication because they just, they seemed they were there, they were helpful, they were doing things, but it wasn't, they weren't really explaining stuff that much, not that I can recall anyway."

(47 year old man)

"The nurses usually didn't tell you anything unless you did ask like I sometimes asked how my blood pressure was and that kind of things and they always spoke, said what it was."

(81 year old man)

One participant indicated the importance of empathetic responses from nursing staff with patients who are scared and worried. She wished for more non-verbal behavior, empathy, and emotional support from the nursing staff.

"... I just wished that maybe somebody would have taken my hand like I mean there has been other surgeries where I've been so, you know worked up, you know the nurse would pat my hand, or say you know it is going to be okay; but, um, I literally laid there, they moved me on the operating table, I had tears streaming down my cheeks you know, and I just kept saying I was sorry and they just sort of kept looking at me and saying it's ok, it will be fine, just so."

(35 year old woman)

- **Provision of timely and sufficient information**

Several participant stories (5 out of 13) indicated the important role of providing timely and adequate information regarding the overall process of acute care, the surgical procedure, and diagnostic test results in patient experience. Their stories demonstrated that providing

information to patients at an early stage of surgical service gives patients an opportunity to learn what to expect, reduce their anxiety, and increase their feeling of certainty and comfort. A fifty-two year old woman described the best time for providing information is the first contact in a hospital ward.

“I think it is very important that initial contact up on the ward it’s made and you’ve given a brief snap of what is going to be happening.”

(52 year old woman-A)

She also mentioned that the provision of timely and adequate information by nursing staff regarding the process of surgical care helped her to “have a plan” for her actual discharge and made her feel more relaxed and comfortable.

“...I knew what to expect and I say that it’s comforting, it’s soothing for patients to know, I mean everybody sort of likes to get home as soon as possible but you know sometimes you need stay a little bit longer and if you know beforehand you’re going to be staying longer, then you can accept it and sort of plan for [it]; but if you never know what’s going to be happening you kind of, you’re always expecting tomorrow maybe I’m going home you know, I mean just knowing it’s comforting ... the more you know what’s going happening to you, I say the better prepared you are, the less anxious you are. we all know, I say attention anxiety can manifest itself in many ways, can actually hinder your recovery.”

(52 year old woman-A)

In contrast, a thirty-five year old woman reported that information regarding the decision for her surgery was not communicated to her in a timely manner and that this resulted in confusion and misunderstanding.

“It would have been nice after, um, right after the CAT scan if they knew just giving me some more info that you know, you are going to pre-op, um, we can’t you know, we don’t have the people available right now to speak to you but just so, there likely would be a surgery involved, so we’re just going to throw you in pre-op and we will come talk to you later; that would have been a better approach than just sort of being thrown me in there, and all of us, our minds was wondering and going, oh! Pre-op, you know, because obviously they knew.”

(35 year old woman)

Another participant expressed his dissatisfaction with not being informed about the diagnosis for a “lengthy period of time” which caused him more anxiety.

“It was quite a bit of a lengthy period of time where I didn’t know what is going on...they finally told me that I had an inflammation or um, I was infected, right, so my gallbladder was infected; so I didn’t learn it until I was basically leaving you know, after 6 to 8 hours they told me it was infected.”

(47 year old man)

In the follow-up focus group, the forty-seven year old man highlighted that “just being left in the dark for hours and not knowing what’s going on” in the emergency room along with poor communication with surgeons, shaped his entire experience as negative. He also wondered who should inform patients about their medical circumstances and from which medical staff is it appropriate to receive medical information.

“From my perspective, the nursing were all very good, um, particularly in post surgery; pre-surgery I guess the issues that I had just being left in the dark for hours and not knowing what’s going on, but I don’t know if it’s a nursing issue or doctor issue.”

(47 year old man)

Another participant in the focus group emphasized that surgeon-patient communication, especially while providing information regarding the surgical procedure, should be clear, personalized, and delivered with compassion. She suggested surgeons should show “a little bit of humanity” in their communication and underscored how this approach reduces patients’ anxiety, making them feel reassured and calm.

“I know for the surgeons they’ve done this a million times I say all routine to them; but they have to remember that this is very first time this patient is having their gallbladder out, their appendix out, and I say they have to remember that these are individuals and as much as you see the million of them, it’s still mine [giggled] and I say they have to remember to keep that a little bit of humanity in there and I know it’s hard for them I say when they are busy; but I’m in the healthcare profession and you know every once in a while you can tell a client is a little bit more anxious, I say just sometime all it takes just a little minute and if you can’t answer the question right now, there is nothing wrong with say you know what, I can’t answer your question right now, I have to deal with somebody else right now but I say I’m

going to try my best to come back you know in an hour or so and deal with you, and I mean people will respond to that you know.”

(52 year old woman-A)

Excellent nursing care

Excellent nursing care emerged as a theme in this study as participants mentioned three substantive topics:

- Treating patients with compassion and respect
- Responding to patient needs quickly
- Facilitating patients physical comfort

Participants identified excellent care when they were treated with compassion, respect, and kindness; their needs were addressed quickly; and the physical aspects of their care such as pain relief, environmental conditions (temperature, noise), food, and clothing (gown) were recognized.

- **Treating patients with compassion and respect**

Participants in this study distinguished the significant role of nursing staff in delivering excellent care. A majority of participants (8 out of 13) expressed that nursing staff treated them with compassion and respect. Study participants described nursing staff as portraying compassion to patients by listening to them, spending time with them, talking with them, and showing interest and concern for them. Furthermore, they described nurses as treating each patient as an individual; listening to, and supporting patients to express their needs; and acting to alleviate patient loneliness and isolation.

“ I have to say all the nurses up on the floor were just excellent, I say they listen to you, I mean you know on the evening specially once all the patients are settled, there is not as much medical intervention you know, they would listen to you I say, I mean the most of them are much younger I say in fact some of them I could have been their mother [giggled]; so, you know just sort of talking, sort of personal, I mean you know sort of they're finding out my stories.”

(52 year old woman-A)

“... the morning that they said I could go home, one of the nurses came in and little bit later said ‘you can’t go home today’, I was still on the Morphine pump and I was still being fed intravenously, and she said you’re not ready to go home, but then later on as they checked all the things and I went home; but I know, I thanked her for her concern and her concern was she didn’t want I have to come back again; so, you know that’s kind of good.”

(81 year old man)

One participant, a forty-one year old man, described how the nursing staff treating him with respect resulted in better outcomes and feeling secure and safe.

“...like I said I was being seen several times, they came over and saw if I was feeling okay or not; and the people were very good because everybody was polite and like I said I felt they respected me; and [they] make sure I was comfortable and that helped, I think that helped to get in the process too because it makes you feel better and if the people who look after you and you know you are in good hands which it makes you feel very good.”

(41 year old man)

Another participant, a twenty-eight year old woman, was fascinated by the nursing care and nurses’ compassion. She described how the nursing staff looking after her was “like her family taking care of her.”

“I would definitely say the nurses did [made this experience meaningful for me] you know, they were like my family taking care of me; like they were so concerned, they talked to me like about personal things when they were you know helping or doing things around the hospital, where they were helping me up, go to the washroom or bring me food, or help me walk around; it was like family taking care of me, it wasn’t like a nurse to a patient, it was a caring in between I think that was awesome, I’ve never had it before either.”

(28 year old woman)

Receiving compassionate care from nursing staff was referred to as “just little things” by a forty-seven year old man. He mentioned that attention paid to the “little things” such as fastening the patient’s gown, demonstrated concern for patient comfort. He also emphasized the importance of these “little things” on his perception of quality of care.

“...nursing staff, they were generally good, um, [pause] I don’t, can’t really think, I guess just little things like some of the nursing staff like you know if the back of my gown was opened and you know, one of them was very friendly and she came and

said 'oh, would you mind if I tied it up' and she tied it up in some special way that everything was tied and closed; you know just little things like that to make me feel more comfortable you know, I think that is an example of just small things that make a big difference in and you know, and just a comfort.

... when they went out of their way to make my experiences as good as it could be like obviously it's a bad experience, because I'm in pain and you know, I'm uncomfortable and so on, it's negative, it's all generally negative, but these little things that they go out of their way to make me feel comfortable as I possibly can you know that was very helpful; it's small, it maybe seem insignificant really, but it is not, it's significant because it makes a difference on how I perceive my care."

(47 year old man)

Although the majority of participants felt that nursing staff were caring and compassionate, one participant, a fifty-two year old woman, perceived that she experienced insufficient care and concern from nursing staff in an emergency room while she was waiting in ER. She felt that the nursing staff should be encouraged to provide more empathy and concern toward patients especially in the emergency room.

"... and then the nurse came up and she said, she called my name and I'm like oh, that's me, and I'm getting up and I'm in pain, so I'm slowly moving and I'm hunched over and I can't take my stuff and she called one more time and then she was walking off to the back, and I'm coming and I like I had almost chased her down the hall, and then I went down there and went to the desk, 'excuse me, excuse me' and I had to say it like three or four times before anyone even noticed me, and I said 'did you called for T...?' and she goes 'oh, yeah', she said 'we got a room for you' and I thought you know if I was a nurse, if I was at that position you know you are dealing with people that they are in emergency, they don't come just you know to get you know take a blood test, I think I would have been a little more patient with making sure that the patient that I was calling was there and you know if they need help getting down to the room. So, that would have been, that would have been something that I was not very happy with and not just for myself, but just you know thinking about some other patients."

(52 year old women-B)

The experience of participants highlighted that listening to, being fully attentive to, and showing empathy and consideration toward patients has a significant impact on patients experiencing nursing care in a positive light.

- **Responding to patient needs quickly**

A majority of participant stories (8 out of 13) identified the timeliness of providing care and services by nursing staff as one of the important factors affecting patient perceptions of their experience and quality of care. The words “right away” were repeated frequently by several (7 out of 13) participants while they were describing their experiences. Their comments emphasized the importance of time in delivering care and services from the patient point of view.

“The nurses came right away, checked your vitals, and you know, and they did on a regular schedule.”

(81 year old man)

“They [nurses] were quick to respond if I needed them, and you know, and always tried to make sure you are comfortable.”

(53 year old woman- A)

Some participants (4 out of 13) highlighted the importance of quick responses to a nursing call button. This immediate attention to patient needs by nursing staff gave patients an increased sense of security and comfort. A twenty-three year old woman described:

“They came when you pressed the nurse button, the emergency button, they came right away, and that part was good. I think, um, the hospital is kind of a small hospital, but it is easier to take care of the patients; so, I actually like the ... hospital ... and if you need anything they come right away and give it to you; other hospitals you get to wait for a while after hitting the emergency button, you get to wait a few minutes. I mean I’m sure hospitals get pretty busy, but, the ... hospital was good, they came right away.”

(23 year old woman)

One participant, a twenty-eight year old woman, described herself as very happy with the “patient care,” since the care provided by nursing staff was preemptive. She was amazed by this situation that she “never had to use the call button once” and highlighted it by saying “it was above and beyond my expectation.”

“I would say like the patient care that would be high up there on the list; to me that means the most; you know what I mean, you’ve even think about you have a call

button, right, but I've never had to use the call button once, someone always came to check up on me ... the nurse I had, and this is very important, I've never had, I've maybe had 2 or 3 [surgery] during my life; as soon as I woke up the next day of course I was in pain, but just the nurses came so often to check up on me, whether it was to change my IV bag, if I needed to go to the washroom, if I needed anything, and you know usually if you need something you've always had to hit the call button, I don't think that I've ever had to hit the call button ... so, I've never had that before ... I've never had to hit it once; so it was really strange, it was so pleasant, I've never had that before."

(28 year old woman)

Two participants, however, stated that response to the call button was too slow and it took "an awful long time" for a nurse to respond. One participant, an eighty-one year old man, described that it was not the fault of the nurses, since they were too "busy."

"I mean it's not perfect because they are so busy you know the nurses, and you ring a bell and they come when they can, but not always as fast as you want them too, but that's at any hospital."

(81 year old man)

Another participant, a thirty-three year old woman, felt she was "unnecessary" or neglected as a result of not receiving a quick response by nursing staff to her use of the call button.

"...When I actually did use my call bell, it seemed to take an awful long time for a nurse to come to my room and that didn't make me very happy because when it was someone like myself who doesn't use her call bell all the time every five, ten minutes, every time I needed a little something I did it myself, but when I actually did need somebody, I think they could have been a lot quicker coming to assist ... I was disappointed, I was quite disappointed you know because I mean the whole all over experiences at the ... hospital was great and wonderful, but that aspect of it, is that I felt I was unnecessary, like I mean that I could hear nurses were chatting in the hallway and joking around, and you know I'm laying in my bed, I can't move, and I've hit my call button and you know I can hear all these chattering going on, but yet you know it took, um, it just took longer than expected for somebody to come in and assist me so."

(35 year old woman)

- **Facilitating patient physical comfort**

Physical comfort, a feeling of well-being including both physical and psychosocial conditions, and environmental factors were emphasized by a majority of the participants (8 out

of 13). Physical and psychosocial conditions mentioned by the participants were pain, vomiting, nausea, and anxiety. Environmental aspects included temperature, light, clothing, ventilation, and food.

Several participants appreciated nursing staff for providing physical comfort, especially in reducing patients' pain; however, one participant described experiencing physical discomfort from an IV needle in her right arm; the arm which she used to conduct necessary tasks.

“...the nurse had to put my, what you call that, my IV, right in the crook of my right arm, I'm right handed; so, every time I did something that buzz was beeping and finally it came out at one point; it was, I remember at night, that night it came out and I told the nurse, I said 'I think there is something wrong with this' because then it was hurting because it didn't hurt before and she felt it, and I could feel the blood or the fluid was coming, leaking, and she said 'oh, it's came out', and I said please put it somewhere else not back there because it has been an annoyance; she did, she put it in another arm and that made things a lot easier because I could put that big thing on that side.”

(52 year old woman-B)

Participant stories highlighted that managing patients' physical and psychosocial conditions, by reducing anxiety, alleviating pain, and controlling vomiting and nausea, and modulating environmental conditions, for example temperature, influenced patients' overall experiences and perception of excellent care.

Anxiety

Several participants (7 out of 13) described the period prior to surgery as an extremely anxious time with concerns regarding the experience of the operating room, seeing surgical instruments, pain expectations after surgery, going under anesthesia, and other adverse events. These factors contributed to patients feeling “scared.”

“The only one thing I felt uncomfortable with, when they put you in the operating room you're still wide awake, and it's a frightening thing when you go in and you see the instruments being counted in, you see some of the instruments that you know they are going to use on you are little bit scary looking, um, I remember the last

thing before I fell under, I remember seeing a long steel tool tube and it scared me; my last thought was that is a tool that they are going put in me [giggling]

(53 year old woman-A)

“...coming out of the surgery that nothing went wrong during the surgery ... that part was good; because I don’t like surgeries because a lot can happen, that could go wrong with the anesthesia; so coming out was pretty good; I was happy to be out of the surgery.”

(23 year old woman)

A number of participants (3 out of 13) mentioned experiencing anxiety and discomfort because of not eating solid food post-operatively. For example, a fifty-two year old woman described:

“I think, um, the main thing and these are really just little things but, I think the big thing was my level of, um, discomfort after the surgery was not the pain or, it was just being so hungry and I, I felt well, I, I, you know I had no problems, no pain, I mean things were you know healing; but, aside from that I felt good, and my biggest level of discomfort was that I was so hungry, I was dying of starvation in the hospital [giggled]”

(52 year old woman-B)

Pain Management

Almost all participants (10 out of 13) reported that they experienced “very severe” or “excruciating” pain for a period of time prior to the surgery. Several of them (6 out of 13) mentioned they experienced acute pain episodes in the early morning.

“I came in to the emergency at about 3:30 in the morning; I had a very very bad pain on the right side and when it, actually it got woke me from the sleep, It was that painful and I’d finally get out of the bed and I couldn’t even crawl get down stairs by myself, I had to call someone like my roommate to help me, and I felt very very sick and nauseous, so I didn’t think that something was right to have that certain pain, so actually I called my parents to come and take me to the emergency.”

(28 year old woman)

“...about 2 o’clock in the morning I woke up with excruciating pain, about 2 o’clock in the morning, and yeah, right across here [he pointed out to his belly] excruciating and I couldn’t get comfortable no how.”

(64 year old man)

Interventions by health professionals aimed at alleviating and controlling patient pain in the emergency room and prior to the operation was reported by several (6 out of 13) of the participants. Study participants appreciated the pain management provided by nursing staff after admission into the emergency department.

“...they right away started me on morphine drip; so it helped with the pain, and it helped instead of just being left in the waiting room to sit there for hours; they really looked after me.”

(35 year old woman)

Two participants reported that receiving excellent pain management in an emergency room provided a level of physical comfort and helped them to perceive their waiting time as not “very long.”

“...they did keep me very comfortable during that time [in ER] you know, they gave me Morphine and Gravol for the nausea and tried to keep pain down...; so I figured out you know, It even didn’t seem that I was there that long.”

(28 year old woman)

“...they could see I was in pain and they took me in the back [ER] right away to try, trying get something taking care of, to relieve the pain, so it didn’t take very long, I think only maybe half an hour before they gave me some Morphine for the pain ... I was grateful to be there just because they could give me the Morphine for the pain and I did have to do that a few times while I was there.”

(53 year old woman-A)

Postoperative pain is an expected outcome for patients following surgical procedure; however, few (4 out of 13) patients discussed postoperative pain management. These patients described their postoperative pain was well managed and they were satisfied with using patient controlled analgesia pumps.

“...they got me up I think the next day to do some walking, and [pause], I had a Morphine pump for pain which I used it if I was going to get out the bed I gave another shot, I think I was given good treatment from the staff.”

(81 year old man)

“...as soon as I woke up [after surgery] that pressure was released and the belly was flatter and there was already some output on the stoma pouch, so that’s

already shown everything is working, and the pain, the pain management was already there ... so every 5 minutes I could give myself one milligram of Morphine, so the pain coming out of the surgery wasn't that bad."

(35 year old man)

One participant in the follow-up focus group mentioned that he preferred not to take any pain medications during post-operative time. He emphasized that while pain management was offered to him, it was his "choice" to decline.

"For pain control I don't think that I really took any pain control after the surgery too much like I think the first night I did a little bit; but, but that was my choice like they offered and I as long as was laying pretty much I really didn't need it and it was only when I moved, and I tried to avoid moving; they offered but I kind of refused it generally but I think that was fine for me."

(47 year old man)

Hospital Environment

Participant stories highlighted the importance of providing and promoting environmental conditions that allow patients to rest and feel comfortable such as: minimal noise levels, dim lights, moderate room temperature, and appropriate clothing. Four of thirteen participants appreciated the level of physical comfort provided by nursing staff. One participant, a twenty-three year old woman, was thankful that nursing staff used a flashlight to check patients during the night which allowed them to "sleep better."

"At the hospital at night they don't turn on all the lights, so they came in with the flashlight, so they let you sleep; other places they turn on the lights and they do whatever they need to do; you could sleep better. Other places they don't really take time to come in with the flashlight just let you sleep; yeah, they came with flashlight they checked the vital sings and then they left."

(23 year old woman)

Two other participants described the importance of room temperature on patient perceptions of well-being and physical comfort and referred to being covered by an additional blanket. A sixty-year old man was happy that nursing staff covered him with an "extra blanket" and expressed his admiration by saying "you don't ask, but they look after you." He also perceived

that the nursing staff understood his level of discomfort with cold temperature, since he was “a little bit old” and “a foreign person.”

“...when they come they check on you, they give you whatever you need it ... even in the night some guys they come and give extra blanket because when you are a little bit old or if you are a foreign person they feel little cold; so he came and gave us [extra blanket]. In the morning the other nurse came and said ‘how come you got so many blankets’ I don’t say nothing, I don’t ask but they look after you.”

(60 year old man)

Another participant, a forty-seven year old man, also mentioned that being given an extra blanket by nursing staff increased his level of comfort.

“...the nurses came by and went out, gave me a blanket you know tried kind of to keep me comfortable.”

(47 year old man)

In the follow-up focus group, a fifty-two year old woman highlighted how nursing staff tried to increase her level of comfort by improving some aspects of the environmental conditions such as reducing her room temperature through the use of a fan. She also highlighted the level of the noise in the hospital and the nursing staff’s concerns regarding her privacy.

“...unlike the gentleman who wanted the extra blanket I say I found I was always hot, so they actually searched around and found a fan for me; um, I was in the step-down unit for one night and of course when you are there it’s a little bit more noisy and they made sure that they keep the curtain a little bit more closed.”

(52 year old woman-A)

Another participant, an eighty-one year old man, described that the level of noise in the hospital and in his room was high and it created more physical discomfort. He described how an “earplug” would be a “cheap thing” to improve patient physical comfort.

“...and they[earplugs]are only cheap little things, but they’ve shaped like a beehive and when they go in they almost completely drown everything out ... but as you know there are lots of noises in the hospital rooms at time; so every night when I went to sleep I put them in, I never slept enough but you know.”

(81 year old man)

A fifty-three year old woman described how she experienced a level of discomfort as a result of a bad smell in a hospital room.

“...the room I was originally in, when you came to see me I was in a different room, but the room they originally put me in, they had somebody in there I don’t know what exactly it was, but they were having to go and clean out, something that would make the room smell so bad and they would have to come in and spray all the curtains and every things after they cleaned this out; so, if I could get out the bed fast enough, I would leave the room for 15 minutes or half an hour, or just hold something over my face because you are in that room with those other patients and you have to deal with it.”

(53 year old woman-A)

In addition, a fifty-two year old woman described how “renovations” at the hospital negatively affected her experience of comfort:

“I think there were some renovations being done at the hospital, so I wasn’t impressed with the cleanliness side of things...”

(52 year old woman-B)

Two participants discussed co-ed hospital rooms and how this produced physical discomfort for them.

“...the other thing that I could raise maybe or I should raise probably is, is the fact when I got there, I was putting into a room with 4 or 3 other people and they were like elderly ladies and it was very uncomfortable for me to be in this room with 3 elderly ladies, um, one of which was very, um, talkative, right, so I had to consistently listen to this person talk[chuckled], I think she’s been there for a long, long time and she knew everything or she thought she knew everything; so, it was just a bit frustrating and you know it’s uncomfortable to be in a room with 3 women, I think that seems a little bit odd, and my wife ended up having me transferred to a semi private room, um, with a man which was a little bit better; but that, I think there is going to be some improvement there, like it seems odd that you know 47 year old man gets put in a room with 3 elderly ladies; It doesn’t seem quite comfortable.”

(47 year old man)

One participant described his dissatisfaction with the hospital “gown” and suggested how a “proper gown” should be designed based on a patient’s needs and privacy.

“I don’t like the gowns they gave you, you know what I mean, you got to hold to it you know, that’s about the only thing ... you know like those two sticky nodes, and

you know I had the pump there, the suction pump, and then intravenous [drip], and you got that gown and try to get up and ... actually even one of the doctors tied my things [ties] I was holding on the strap, yeah, you know what I mean it was kind of open and so, yeah, it was the only thing. If they can do something even like the pump they just clip it, take it into your pocket and put it in there because it was falling down all the time. It should be more, more research into proper gown when you are going to carry all that equipments, yeah, proper gowns ...”

(61 year old man)

A thirty-five year old man mentioned the importance of “frequent dressing changes” in enhancing patient comfort and reducing nosocomial infections.

“...there were frequent dressing changes like kept the infection to the minimum... I thought it was good as good as you can get.”

(35 year old man)

He also pointed out that providing and promoting physical comfort should be considered a high priority for all healthcare professionals and compared a hospital room to a patient’s home. The thirty-five year old man also made suggestions regarding health professionals’ behavior based on this comparison, stressing all the environmental aspects mentioned by other participants such as light, noise, temperature. He also spoke of the importance of respecting the privacy of patients.

“All healthcare professionals: doctors, nurses, healthcare aides should leave the room the way they found it. when they come in, the door is closed, the light is off [chuckled], the curtain is closed; they always come in most of the time, they open the door, turn lights on [chuckled], open the curtains and then take your blood pressure or whatever and leave with the light on and, the door opened [chuckled], the curtain opened; most of the time they wouldn’t leave it the way they found it, and then you have to ask them and sometimes they just leave quickly and you got no time to ask them; you got the noise from the hallway, and lights on and you try to sleep.

I feel like going to all the nurses’ houses, going to their house open all curtains, turn on all the lights, and leave all the door open, and then just walk away... The light should be off unless they’re use it, the door should be closed; it’s like a bad habit almost all of them have and if you don’t ask them before they leave, and they leave fast sometimes; and even sometimes you ask them and they forget before they leave; that’s tough to get rest on the all extra light, sound and noise; and few of them very few actually do it, like leave it the way [it is], I think they should leave it the way they found it and/or ask patients what they want; very few was like that

'would you like light off, the door closed, curtains closed.' Most of the time they just don't care; I don't know, they are in a hurry I guess.'

(35-year old man)

Timely access to surgical services

Access to surgical services in a timely manner was mentioned by the majority of participants (7 out of 13) and represented a fundamental factor in their experiences and overall perception of quality surgical care. A few participants (3 out of 13) appreciated that the surgical services they received were “fast” and they did not “have to wait for surgery or anything like that.”

“I value the most that it was done quickly; um, you know I didn't have to wait for surgery or anything like that ... I have to say the most thing that I appreciated the most was, you know, how fast I was taken in and looked after; you know, not left to sit.”

(35 year old woman)

A fifty-three year old woman's story clearly emphasized the importance of timely access to acute care service as she described:

“...It didn't take very long, I think only half an hour before they gave me some Morphine for the pain and very short time before the doctor came in and examined me; and it was maybe a 2 hour wait, and they've already had me admitted up in the room ... At the ... hospital, they were very good! I had another experience there and I haven't ever liked the hospital, but I was very happy this time around and I like they took me in quickly, they took care of the situation.”

(53 year old woman-A)

Timely access to surgical services emerged as a theme in this study as participants described their waiting experience in relation to two specific subjects:

- Length of waiting time in the emergency room
- Availability of diagnostic services

- **Length of waiting time in an Emergency Room (ER)**

Almost all participants (10 out of 13) in this study mentioned the length of waiting time in an emergency room as a relevant factor regarding access to acute care surgical services. Waiting

time in an emergency room (ER) referred to the length of time that patients stayed in the ER waiting to be admitted to an acute bed, examined by a doctor, and receive appropriate care. Participants in this study described various experiences regarding the waiting time in an ER. Their stories indicated variability in the perception of length of waiting time. A minority of the participants (3 out of 10) perceived that their waiting time in an emergency room was short and that they had been admitted “right away.”

“...we went to the ... emergency because it [pain] was very severe and they could see I was in pain and they took me in the back right away.”

(53 year old woman-A)

“...they’d kind of guessed that it was my appendix like I did, and they admitted me right away.”

(28 year old woman)

A thirty-five year old woman experienced no waiting time in the emergency room. She said she was “lucky” since nobody was waiting in the emergency room when she arrived. She also valued that the care provided to her was within an appropriate time.

“when my husband and I arrived at the ... hospital, um, there was no one in the waiting room, so I was taken in right away which I very much of course appreciated; I just happened to get lucky I guess, I was given a bracelet right away, I was checked for temperature, blood pressure, that sort of thing; um, I very much appreciated the fact that it didn’t take them too long after a nurse come in and examined me and felt my abdomen and such that.”

(35 year old woman)

On the other hand, a number of participants (4 out of 10) perceived that they had a prolonged waiting time in the ER. They pointed out that the prolonged waiting time in the ER was a result of overcrowding. One participant acknowledged ER staff efforts to provide a good quality of care in these over-crowded circumstances.

“It was very busy, so, considering the amount of people they had in there I guess the staff was doing the best job that they could.”

(52 year old woman-B)

A twenty-three year old woman expressed her frustration at waiting in the ER for a long time despite having a referral letter from her family physician. Her story demonstrates that prolonged waiting times can cause additional, unnecessary stress and anxiety to patients already suffering from a medical condition.

“...well you have to wait for couples of hours which wasn't good ... you get a wait like hours ... I just wanted to go home actually because you are waiting so long and you are in so much pain and you just, it just takes forever; so, I was kind of annoyed and mad about the whole thing that I had to wait plus my doctor sent me there and they called and she sent me a letter for the doctor to get me in faster, but it didn't work pretty well though.”

(23 year old woman)

She also perceived that overcrowding in the ER is often caused by a shortage of doctors combined with an increase in the number of patients.

“I was [giggled] I was there [in emergency room] for a while [giggled] actually because they only have an emergency floor, they only have two doctors, and they have so many other patients so they're just back and forth, so you can't and you have to wait a while for everything; so, I was there since 10 [a.m.] to whenever they transferred me to the ... hospital; I was there all day.”

(23 year old woman)

A fifty-two year old woman described waiting time in an emergency room as “inevitable” and that the length of waiting time varies based on how crowded an emergency room is.

“...I mean, obviously there's always going to be some waiting involved, I mean that it's just inevitable, I mean you can't go in and have you out or whatever, I mean just certain things just have to happen ... obviously things could always be better, but I mean it all depends when you're coming to the emergency how busy they are, I mean that's, I mean in an ideal situation everybody would seen in within 5 minute, but I mean that's not realistic; I mean they triage them you know, I just say that's a tough one.”

(52 year old woman-A)

Likewise, a sixty-year old man described waiting time in the ER as unavoidable, since doctors require time in order to make an accurate diagnosis. He perceived his time spent waiting

in the ER as “average time” and identified that one’s triage priority level affects the length of waiting time in the ER.

“...I say for me it was an average time because they had to get the information, doctor had to come and check on you what is wrong; um, some people complain they don’t do it right away, but you know doctor is not available and then they had to assess you what’s really a problem ... so anyway for me it’s average time; I wish they could do it in 5 minutes ... you know, I mean like I said right away go to the hospital, right away they know the problem, right away they operate that would be good instead of waiting until the following day in the morning, you know but it’s not reality, reality they have to find out [the problem] and then they might find somebody has a heart attack and he is ahead of me.”

(60 year old man)

A fifty-two year old woman’s story illustrated the importance of an accurate triage assessment and its impact on length of waiting time in the ER and on consequent outcomes. She perceived that her prolonged waiting time was as a result of an inaccurate triage assessment.

“...[I waited] quite a while, I guess they didn’t consider it to be you know a top priority; I’m not sure how they lined up you know what’s the priority and what isn’t, but yeah, I waited quite while.”

(52 year old woman-B)

Her story also highlighted the substantial role of dialogue and communication on a patient’s perception of waiting time in the ER.

“...once I got in which took almost 4 hours ... I think that all went pretty good ... I had a nurse came by and apologized ... actually she came by and apologized for I guess not being quicker to determine because then I probably wouldn’t have waited that long, so she came by and apologized for that.”

(53 year old woman-B)

Another participant, a fifty-two year old woman, stated that a prolonged wait time in the ER was an obstacle to accessing healthcare services.

“I think it’s the emergency, I mean they’re just so busy down there ... sometimes the long wait in emergency is kind of deterrent to people who want to come in ... that’s the only thing that I found a little bit sort of frustrating...”

(52 year old woman-A)

A twenty-three year old woman expressed her fear and anxiety of waiting in the ER by referring to some adverse events that were supposed to have happened to other patients in an ER. She also emphasized that the wait time in the ER is a barrier to accessing healthcare services.

“...in the ... [ER] a couple of people died waiting to go see a doctor which is not good; so, they need to fix that part. If you’ve already in the hospital, you’ve already seen a doctor and everything, it is pretty much ok; um, you have a room and they care for you, but it’s getting in there is a problem from the emergency.”

(23 year old woman)

Participants in the follow-up focus group emphasized the importance of waiting time in the ER on overall patient experience. One participant, a fifty-two year old woman, described:

“I mean it [wait time in ER] could be 6 to 8 hours and that means for somebody who is in pain like 6 or 8 days [giggled] and I mean that is where the frustration rises.”

(52 year old woman-A)

- **Availability of diagnostic services**

Participants in this study mentioned several diagnostic services including blood tests, X-rays, ultrasounds, and CT-scans provided to them prior to their surgery. A number of participants (4 out of 13) stated that diagnostic services such as ultrasound and CT-scan were not available at the time they were required. Their stories highlight the importance of having these services available in order to ensure timely access to surgical services. Two participants expressed their dissatisfaction with the unavailability of diagnostic services during the long weekend.

“...they’ve already had me admitted up in the room, ... it was the Friday of the long weekend, so I think that a lot of things may have not been available during the long weekend, but once they did the blood test they could tell that my liver had been affected and they wanted to keep track of that.”

(53 year old woman-A)

“...they took some X-rays and they weren’t able to diagnose me and they felt that it is probably a gallbladder issue, but they weren’t certain, so they had to book an ultrasound, but it was a long weekend so nobody was working on the long weekend for the ultrasound, so we had to wait until Tuesday or Wednesday to book the

ultrasound for the Friday, so, it was quite the lengthy period of time before to get the ultrasound.”

(47 year old man)

Participant stories indicated restricted access to diagnostic services in the evenings and early mornings might postpone patient access to surgical services. One participant stated regardless of how quickly she was admitted to a hospital, her surgery was postponed because of the unavailability of ultrasound services.

“I think we got arrived maybe around 4 a.m. at the ...hospital [ER] ... and they admitted me right away, they brought me to a room, oh, the doctor came, but I could not get ultrasound until 8 o’clock when it opened.”

(28 year old woman)

Another participant, a sixty-four year old man, felt his surgery would have happened sooner if the diagnostic services were available “after 4 o’clock [p.m.]” and maybe then he would not have had to stay “an extra day.” He emphasized the importance of enhancing the access to diagnostic services in a hospital by comparing it with the availability of 24 hour emergency plumbing service.

“Some of the services are not available when they’re required, yeah, you have to wait for the service [pause], you know if your hot water tank blows in your house you can get a 24 hour service now [chuckled]”

(64 year old man)

In addition, participants in the follow-up focus group underlined that wait times, both in the ER and to access diagnostic services, are one of the most important factors in shaping a patients’ experience. A forty-seven year old man emphasized that it is necessary that ultrasound services be available all the time.

“...that whole waiting times just didn’t seem as right like especially waiting 5 to 6 days for ultrasound to me they should have the ultrasound like right there, why can’t somebody be there and doing the ultrasound, like that to me was crazy.”

(47 year old man)

Another participant in the follow-up focus group who identified herself as a “health professional” indicated work hours in the healthcare system should not be limited to a routine work hours “from 9 [a.m.] to 5 [p.m.]” and should be “a little bit more portable” to decrease the wait time for diagnostic services.

“I mean I work in the health profession and I mean I kind of like okay everybody wants the 9 to 5, but I mean I’m going yeah there is certain things that um, it’s like saying we are going to have X-ray only from 9 to 5, I’m going you know, there is going to be something a little bit more portable I mean a little bit more [portable] yeah.”

(52 year old woman-A)

Continuity of patient care

Continuity of patient care in the surgical unit was generally defined by study participants as seeing the same surgeon who performed their surgery following the surgery and during the patient’s post-operative stay. Several participants (5 out of 13) reported that they have never seen the surgeon who performed their surgery during their post-operative stay.

“The surgeon never came by, we had what you call those doctors in between; I never saw the surgeon, he came by and said hello, but I’ve never seen him after the surgery.”

(53 year old woman-B)

One participant, a forty-one year old man, clearly expressed his desire to speak to the doctor who actually performed his surgery after the surgery even though another “doctor did tell him the details and did answer his questions.”

“I think it would have been good if I was able to speak to the doctor who actually performed the surgery after my surgery because the doctor that [pause], I knew the name of the doctor that was going to do the surgery, he came to me a day before and told me that he would be doing it, however, when I was in the, um, operating room he was not the doctor that I saw, maybe he came after I went to sleep I don’t know, and the following day a fellow came in to talk to me, he was an assistant surgeon to the best of my knowledge, but I actually wanted to talk to the doctor who did the surgery, just to, just to do a follow up, so I knew exactly what happened; however, that doctor did tell me the detail and he did answer my questions, but I thought it would be great if it was the person that I actually talked to or who

actually done the surgery. I think I did [ask about the surgeon], but, I think he was not available at that time, but I could be mistaken because of the person who did my surgery, his name was doctor X, and I think I spoke to doctor Y afterwards, so. But that was not, that was not terribly important, but I thought maybe it would have been a little better if I had that.”

(41 year old man)

In the surgical unit, continuity of patient care was more likely to be experienced by those who had stayed in the hospital for a longer period of time (> 1 day), and those who had been transferred to ACS sites (4 out of 5).

“...I had to stay extra days ... during those extra days that I was there again a bit frustrating because each day new surgeons would come in, or new doctors would come in that I didn’t know, right, so I had, I had so many doctors, um, you know ... I had the initial people at ...[first] hospital, I had the initial surgeon that came in for 5 minutes, that’s when I arrived at the ... hospital; I had a surgeon and his sidekicks that saw me the day of the surgery, um, and then after the surgery like each day somebody would be doing rounds, but it didn’t seem to be, like I never saw the surgeon who did my surgery after my surgery, it was always somebody else, um, so, I was a little bit frustrated that there wasn’t that consistency.”

(47 year old man)

Participant stories highlighted two aspects of continuity of care:

- Interpersonal continuity
- Informational continuity

- **Interpersonal continuity**

Participant stories highlighted the value of building an ongoing personal and trusting relationship with their surgeon and other care providers. For instance, a forty-seven year old man described that a lack of interpersonal continuity in his experience with acute care surgical services resulted in an overall negative experience. Although he acknowledged “different shifts” in a hospital setting, he believed it is important to have a consistent relationship with one surgeon during the post-operative stay.

“...it just went from surgeons to surgeons, like I saw so many doctors, and there wasn’t that consistency of sort of seeing; like I understand that you know it was over the weekend, and there is night, there is like different shifts, and so on, that’s

understandable; but I think there is a need to be some kind of consistency like even during the day like the surgery occurred on the Saturday, um, yeah, so, Friday night when I got there was one surgeon, Saturday during the day was another surgeon, um, Sunday, I think it might been the same surgeon, but it was his sidekick [resident], I don't know what it is, the person who assist him came in to see me ... and then, um, during the week, on the Monday and Tuesday there was some, um, completely different doctor that I didn't even know who she was actually, she was who ultimately discharged me, but I didn't even know who she was or her role was."

(47 year old man)

An eighty-one year old man perceived not seeing the same surgeon after surgery as a consequence of the consolidation of surgical care services.

"...then I don't think I saw [my surgeon], I think with their new system you don't see the surgeon after the surgery, it was a team of doctors they came around each day so."

(81 year old man)

- **Informational continuity**

Participant stories identified that receiving reliable medical information from different care providers along with consistent communications among them provides informational continuity and makes patient care coherent and consistent. A fifty-two year old woman mostly valued inter-professional communication and described how increased communication among nurses and doctors enhances collaboration and results in better continuity of care.

"I value most the communication that they provided to the patients ... you know telling you what's going to be happening ... the communication with the patients, and how well they worked together as a team... the level of the communication with patients, with each other; they worked well as a team."

(52 year old woman-A)

In contrast, another fifty-two year old woman had a different experience and described that the lack of informational continuity among healthcare providers resulted in a high level of "discomfort," and suffering from going without food.

"...my biggest level of discomfort was that I was so hungry, I was dying of starvation in the hospital [giggled]... he [doctor] said we're going to put you on

solid food and I thought good because I was starving, but you know, he didn't do it, he didn't put the order in, so when they came at lunch which I was so looking forward to, um, it was all liquid again and I questioned it and I was told well the order wasn't changed, you're supposed just to have clear liquid."

(52 year old woman-B)

A twenty-eight year old woman described that lack of informational continuity regarding her post-operative care resulted in a feeling of uncertainty.

"...after the surgery when I woke up, my ER doctor did not come once to talk to me, he actually, I was actually told from my mother he called up to the room ... and he explained the surgery went well which was good news, but also things for example that I'm not able to do like I'm not actually able to work out, as well as a nurse I do teach, I teach Yoga and Pilates class and I was told with him that I'm not able to do that for 2 to 3 months, but I did not hear anything like that from him and I'm going with word of mouth; so, to this day I don't know, ... I'm still uncertain about what I can and I can't do ... I thought that should definitely be clarified before I left the hospital, because the nurses, doctors, and staff don't know what was going on."

(28 year old woman)

In the follow-up focus group, participants discussed their perception of continuity of care and clarified that continuity of care in the surgical setting mostly refers to seeing the same surgeon who performed their surgery post-operatively. One participant again emphasized that lack of continuity of care in his experience resulted in his increased discomfort and distress.

"... yeah that pretty much captured my experiences I guess the negative experiences that I had the comment about not seeing the surgeon that performed my surgery, the surgeon that saw me when I arrived at the hospital where the surgery was to be performed, um, was not very informative and very rushed it seemed; and the surgeon who did my surgery I never saw him again afterward and the people they came afterward, um, they were all different like every day was like I was seeing somebody different, different resident, different people. I just never, from the surgeon perspective I never had any sort of consistency or comfort in any way really. So I think those experiences pretty much is captured in your findings there."

(47 year old man)

In contrast, another participant appreciated that the same surgeon visited her during her hospital stay. She also highlighted that the surgeon's presence on her discharge day was an important factor in her perception of continuity of care.

"...unlike the other gentleman, I had the continuity of care; the doctor that operated on me I say I saw him very briefly in post-op, and he came and saw me the next day. I was there for a couple of days so I mean he didn't see me every day, but I say he was there on my discharge [day], well, it was supposed to be my discharge day, and you know when, what I thought that would have been normally the nursing duty instead of [doctors] going through the discharge procedures, he actually went through with me and he looked at me and said, well, I had a drain, and he goes well and said 'you don't want to come back next week, do you? What about I take it out right now?' I say you know in that aspect he was really good..."

(52 year old woman-A)

Patient safety

Patient safety, as a core component of quality of care, emerged as a theme in this study as a number of participants (4 out of 13) highlighted some aspects of patient safety including:

- Potential medication error
- Post-operative adverse event

Although participants in this study did not directly employ the term "patient safety," their stories mentioned near miss events that could have potentially harmed patients or resulted in patient complications and injury. Patient safety is referred to as "the prevention of harm to patients" (Aspden et al., 2004, p.5); however, participant stories indicated that patient safety was not limited to solely avoiding harm. Patient safety also incorporated delivering timely and appropriate care and involved carrying out actions that minimized patient exposure to unnecessary risks in the healthcare environment

- **Potential medication error**

Medication error, as a preventable event, refers to errors occurring in the process of using medications including the ordering, transcribing, providing, administering, and monitoring

medications. Medication errors might have no or few consequences to patient health or may be potentially life-threatening (Ferner & Aronson, 2006).

One participant in this study, a thirty-five year old man, reported a potential medication error. His story indicated that he could have been harmed by a medication error; however, he avoided the adverse outcomes through his own initiative and chance.

“...good that I looked at the pills and noticed the difference and I didn’t just down them.”

(35 year old man)

He mentioned his initial painkiller was changed to another painkiller to which he was allergic. His story indicated errors could happen in any step of the medication use process, but he emphasized that he believed that lack of communication and patient chart review were primary causes of this event. His story highlighted both system failures and human factors as causes for the potential medication error.

“...they switched me to a different painkiller all together that I’m allergic to; so they didn’t communicate with me at all, they didn’t talk to me, they didn’t even read my chart; the doctor switched me from Morphine to Tylenol 3, and I’m allergic to the Codeine; so, one time the nurse shows up and I was expecting Morphine pill and there was different pill on that, ‘what’s that?’ like she didn’t even tell me what it was, I had to ask; almost one Codeine wouldn’t do all that much to me, but if I kept taking it for a couple of days my hands would be swollen and become very itchy; so I was switched to another painkiller that I’m allergic to without, they didn’t even talk to me if I’m in less pain, or what I’m allergic to, like in my bracelet is said Codeine, it’s in my chart Codeine, and they switched me to the Codeine; they didn’t talk to me or even read; that was kind of [pause]I don’t like that ... that was the worst part that they switched my pill without talking to me, and gave me something that I’m allergic to.”

(35 year old man)

He also highlighted the important role of communication in monitoring and changing a patient’s medication and pain management plan to eliminate possible risks and improve patient safety. His story reinforced that if potential medication errors are not eliminated, then an adverse event could be the result.

- **Post-operative adverse event**

An adverse event is an unexpected and undesired incident that occurs during the process of providing care “by an act of commission or omission rather than by the underlying disease or condition of the patient” (Aspden et al., 2004, p.201). Adverse events which may result in patient injury, prolonged hospital stay, or death (Aspden et al., 2004; Baker et al., 2004) were mentioned by two study participants. Their stories included adverse events caused by medical complications of a procedure which negatively affected their prognosis and led to prolonged stay and recovery.

A twenty-eight year old woman described how she incurred adverse outcomes through inappropriate post-operative wound care instructions given to her by a medical resident. Inappropriate post-operative wound care instructions caused the patient serious adverse events such as a wound infection and burns that negatively affected the progress of her recovery.

“I would say near the end, um, there are residents on duty as well, so of course they’re learning and asking questions, um, but the doctor she saw me before I left told me something that just didn’t add up, um, like for example my steristrip; as a nurse I know they are not supposed to be wet, I should put a bandage over top, and they actually told me, she pulled off the bandage herself before I left and I had just these strips showing ‘well you have some blood that it’s a little bit soaked through’; it is not clean, it’s not sanitary, and she actually had told me I can shower that way! Another thing she had told me was to put heat on all the time what the heat did was it caused the burn on one side of my mid section, I actually had to go in get antibiotic cream for my family doctor yesterday.”

(28 year old woman)

Her story also indicated that the adverse event not only harmed her and prolonged her recovery but also had a negative impact on her trust in medical practitioners.

“...So, as a nurse is hard because I know, I know certain things, it doesn’t mean I’m right every time and everything I say should be right, but coming from like a doctor how can it be so totally different you know what I mean, yeah, two different instructions, so then I called the surgeon’s office and explained that and she said number one you never put heat, you are not supposed to do that, it’s already peeling off the strips which isn’t good, nothing is healed; and second you should have always bandage over top and you do not get them wet! So, I kind of felt like it’s two sides and I don’t know who to believe or what to believe, it’s just ended up I

was doing something wrong and now it has to be fixed; so, I mean it's already painful and you don't want, I have swelling, I have burns [giggled], and it's very, very irritated; so now that has to be taken care of."

(28 year old woman)

Another fifty-two year old woman experienced a life-threatening post-operative adverse event, wherein she was at risk of death for "48 hours." She perceived that this unexpected and undesired outcome was created by unsafe conditions and delays in medical interventions.

"Well, I went in with appendicitis; um, I was good for the first day and around 11:30 the next day evening I couldn't breathe; I was gasping for the air and I let them know a few times and I'm not sure what they said but I don't know if they put me on a little of oxygen, I don't really have that much memory of that, but every time they came in I kept telling them that I couldn't breathe; so, 11:30 at that night, the day after my surgery they took me for X-ray and then came back and it wasn't until 14 hours later that they sent me to the ICM [Intensive Care Medicine] where they, um, I think I was totally out, the machine was breathing for me, like they put, I forget what they call, where a breathing machine was right into my lung and I was out for 48 hours; and ... see in 48 hours if I wake up for matter or whatever I can breathe on my own."

(52 year old woman-A)

She described her uncertainty of what happened to her and what was the actual cause of the adverse event; however, she viewed the event as a major medical complication resulting from what should be a "very simple operation."

"...so it was very confusing, everything happened so weirdly; um, I had everything attached to me, um, from very simple operation to something that went wrong. so today I still don't know what happened; I got pneumonia, my lungs filled with water or some sort that I couldn't breathe; and then I was at ICM for 48 hours with unconscious, yeah [giggled]; so I don't know... nobody really told me what happened; if it was infection that goes into my lungs, if it was something else, nobody really told me [pause] what went wrong [pause, then giggled]... I don't know if my appendix had been ruptured before the surgery or during the surgery; still don't know that."

(52 year old woman-A)

She perceived inadequate nursing care as a potential cause of the adverse event.

"...because my sister-in-law is a nurse, they [nurses] should be turning you or helping you every 3 hours you know put your back in the bed; and I had a night nurse that I called her because I was all scrunched up and couldn't move, I called

the button and I asked her if she could help me to straighten up a little bit and she said 'ok, well', you know, 'just push up a little bit', so I pushed up again, 'a little more', so I did all by myself; so she didn't help at all."

(52 year old woman-A)

She mentioned several times that the delay in responding to her shortness of breath led to the adverse event. She believed this serious adverse event would not have happened if healthcare providers had been more prompt. Her story emphasized that adverse events in post-operative care were caused by both system failures and human factors and could have been avoided.

"...but it was just kind of amazed me that it took 14 hours for them to really do something because I think I wouldn't have gone that bad if something would happen faster; from the X-ray at 11:30 at night to 14 hours later I don't know if anybody looked at the X-ray, or they looked at it and thought, oh, well, I don't know; I went through the whole night 14 hours of, it wasn't almost until 2 o'clock the next day that they took me into the intensive care [Pause] & [giggled]"

(52 year old woman-A)

A sixty-year old man's story illustrated that patient awareness of a medical situation might increase patient involvement in patient safety strategies and eliminate potential medical error. His story demonstrates that his concern as a "diabetic" patient resulted in inquiring if there is any sugar in anything he eats.

"There was a nurse I told her I'm diabetic, so I told her if she can see the Jello, they gave me Jello for three days because my bowel needed to be opened up a little bit and not too much food you know, so I asked her if she could see there is sugar in there because diabetic sugar you know I should have without sugar, but she said 'oh, no, no, it's a 50 calories; don't worry about', but that's not the point; but I wasn't worried about it because even sugar was inside they would give you right away insulin to come it down, It wasn't very critical for me, but sometimes some nurses don't think."

(60 year old man)

Transferred patient experiences in a consolidated ACSS

This section provides an overview of transferred participants' perceptions of the consolidated ACSS and identifies factors that appeared to affect patient experiences. Participants were asked to share stories about their transportation experience if they had been transferred to another

hospital to receive emergency surgery. They were also asked to describe how they found out about their need for transfer and what their feelings were regarding this necessity. The following findings are based on an analysis of these data.

Almost half of participants in this study (6 out of 13) were transferred patients who needed to be relocated from an emergency room to an ACS site to receive acute surgical services in the Winnipeg Health Region. Participant descriptions of their experiences showed how transferred participants had different experiences than non-transferred participants as a result of the need for transportation. Transferred patients also had various perceptions regarding their transfer to an ACS site. A twenty-three year old woman's story indicated that transferring to an ACS site was not her choice; however, she had to be transferred to the ACS site in order to receive surgical services.

"...then they realized that it was my gallbladder, and they don't do the surgery there, so they had to transfer me to the ... Hospital ..."

(23 year old woman)

A fifty-three year old woman perceived her overall experience of transfer to an ACS site as "pretty good." She described:

"...once they determined it was appendix [appendicitis], they did more tests to kind of get ready for the operation I think, and then they put me in an ambulance and took me to the ... hospital; so, I think that all went pretty good."

(53 year old woman-B)

Similarly, a forty-seven year old man expressed his transfer to an ACS site as "okay." He perceived the need for his transfer was as a result of lack of "expertise" during the night and weekend shifts in the initial hospital.

"I felt that [transferring to another hospital] was okay, like I understood that it's okay, the people here may not necessary have the expertise especially that it was in the middle of night, it was on the weekend, I could understand that they don't have the expert that could make a diagnosis and they have to move me, Okay."

(47 year old man)

A sixty year old man perceived transferring to another hospital as a privilege in that he would have access to “the best services.” He described how “the doctor arranged everything” for him to be transferred to a “well equipped” hospital. He specifically mentioned consolidation of surgical services as the structural reason necessitating his transfer. However, his reference to the consolidation of surgical services pointed to the non-emergency surgical services.

“...when they found out there was something wrong on the x-ray, they, I think, ... the doctor,... she arranged everything; so, she told what was the problem [and] when I am coming... I was happy because I was there before and, um, I mean I know that not all the operations would be done here, or there, different operations go to somewhere else; and the ... hospital is well equipped for anything anyway.”

(60 year old man)

An eighty-one year old man described his concerns with consolidating surgical services. First, he expressed his appreciation for the availability of “lots of hospitals” in his neighborhood, and then he expressed his apprehension about reorganizing surgeries at “certain” hospitals.

“But yet we are thankful we have a hospital you know; well, there are lots of hospitals around here, but they’re streamlining like all surgeries at the certain kind of one hospital, that’s what they are trying to do, isn’t it? I guess it is alright, but [giggled]?”

(81 year old man)

Factors affecting transferred patient experiences

In addition to the other significant factors identified previously in the first part of the findings, the following factors appeared to affect transferred patients’ experiences:

- Transfer to an ACS site
- Communication regarding transportation to an ACS site
- Process of admission to an ACS site

Participants’ experiences relevant to each of these factors are explained below.

Transfer to an ACS site

A majority of transferred participants (4 out of 6) relayed how transferring to an ACS site was strange, alienating, and made them feel annoyed. One participant expressed her irritation as “far away from home” and highlighted her concerns that “the hospital closest to you can’t even care for you.” However, high quality of care provided at the ACS site decreased her annoyance and enhanced her perception of the whole process of the acute care surgery.

“I was kind of annoyed [giggled] because it was far away from, like from home, so it was harder for my husband, and they came and visited me all the time, but it had been kind of ok; It was pretty good there, It worked out, so. It is annoying to being transferred because the hospital closest to you can’t even care for you because they don’t do the surgery anymore; so, that part sucked; it wasn’t very good.”

(23 year old woman)

Prolonged waiting time in the ER at the initial hospital made her transferring experience more frustrating.

“...just don’t like waiting there for a day [in ER] and then getting transferred; that part is annoying.”

(23 year old woman)

A twenty-eight year old woman felt that relocating her to another hospital was “kind of odd.” She was not happy to be transferred to an ACS site. Her story indicated “the transportation part” was the worst part of her experience.

“One thing I didn’t like was the transportation part of it; at...hospital, they don’t do emergency surgeries, so I was transported by Medi-Van down the bumpy construction field road which wasn’t so good when you are in pain; so that was the only thing was the transfer which was kind of odd to me; my surgery was supposed to be serious.”

(28 year old woman)

She also described transferring her to an ACS site added more stress, increased her level of discomfort, and made her feel more vulnerable. However, she did not blame the hospital or health care professionals for not being able to perform her surgery at the first hospital.

“when I was transferred to the ... hospital, well the transportation, I mean it’s not, I mean whose fault is it that I couldn’t have my surgery there, but it was very hard when you are in pain, you don’t have an IV yet, nothing, and you’re being transported down like a very, very bumpy road, it wasn’t that pleasant, it hurt even more.”

(28 year old woman)

Similarly, a forty-seven year old man described the fact that he had to go to a different hospital seemed “a bit odd.”

“the fact that I had to go to a different hospital it did seem a bit odd like why the doctor couldn’t come to see me, couldn’t, maybe it could have been easier for the doctor to come from [another] hospital over to [this] hospital to make the assessment.”

(47 year old man)

An eighty-one year old man said he was “surprised” by a doctor’s decision to transfer him to another hospital. He suggested that the unavailability of his previous surgeon might have been the reason for his transfer.

“...we got there [hospital] about 4 o’clock and waited about 2 hours to get in to a bed; and they took me for test and so on, and [doctor] decided that I should be transferred to the ... hospital which in a way surprised me, but the surgeon that he’s done my other surgery was in ... hospital, but he was on holidays, so whether it had a barrier on that but I’m not sure.”

(81 year old man)

He also mentioned he was not “upset” by the transfer to an ACS site and “accepted” this situation.

“I wasn’t upset; it was something that had to be done, so I just accepted it.”

(81 year old man)

A twenty-three year old woman expressed surprise at being transferred by an ambulance instead of “stretcher service vehicle.” She did not consider her condition as an “emergency” situation and a “need to be in an ambulance.” She indicated that her surgery was performed “right away” after her arrival to the ACS site.

“I just found it weird because ambulances are so expensive, I’m covered, but they are expensive; I wasn’t in an emergency and I didn’t need to be in ambulance because, I don’t know, like it’s just they found what it was and they were not going to do anything, so why they were sending me by ambulance? They could use the stretcher service vehicle, but they had chosen an ambulance, I don’t know.”

(23 year old woman)

Her story also illustrated how she perceived her insurance coverage as contributing to the use of an ambulance for her transportation.

Transferred participants described their experiences respecting the transfer to an ACS site in four categories:

- Waiting to be transferred to an ACS site
- Condition of roads
- Difficulty for patient’s family
- Risk involved in transfer

- **Waiting to be transferred to an ACS site**

Waiting to be transferred to an ACS site, defined as the time that elapses between when a patient was informed of their need for transfer to an ACS site until the arrival of a vehicle to pick up the patient, was mentioned by almost all (5 out of 6) transferred participants. There were variations in how transferred patients perceived this waiting time; however, half of the participants (3 out of 6) perceived the waiting time as “long.” A forty-seven year old participant described how he waited “two to three hours” to “get a ride” to an ACS site. He described how the hours spent waiting for an ambulance to arrive were “a little bit troublesome.”

“...the fact that I had to wait four more hours to get a ride that was a little bit troublesome you know, I was just waiting again and again like I had already waited quite number of hours and I have to wait more hours to get a ride over; that was a bit frustrating, but again like the actual moving me that process was fine, um, I mean getting me up to my room that all was fine; so, it’s really it was the wait that was troublesome.”

(47 year old man)

A twenty-three year old woman also expressed her frustration at waiting a long time for an ambulance to arrive.

“At the ... hospital, they just told [me] they don’t do the gallbladder surgery there anymore and they had to transfer me to the Hospital, but waiting for the ride took quite a while.”

(23 year old woman)

Another participant indicated her concerns about transportation delay. She described how she was waiting for a Medi-van about an “hour, hour and half;” even though her surgery was “really serious” and time-sensitive.

“It took about hour, hour and half for the ball to get rolling to have the Medi-Van to come and pick me up, so you know maybe it would the type of surgery you know it was really really serious, I wish they were a little bit quicker, but when you think about other experiences, the one you hear, waiting one and half [hours] to be transferred isn’t so bad, when you see the people sitting in the emergency for hours at the time even to be looked at; so, yeah, I would say that would, that was kind of strange just waiting that long, but then when you look back on it, it really isn’t so bad.”

(28 year old woman)

In contrast, two participants reported that the waiting time to be transferred to an ACS site “was not a long time.”

“...so, then I waited until they had things set up ... I don’t know how long I waited once they said that I was going, it wasn’t a long time.”

(81 year old man)

A sixty-year old man described how he waited only “twenty minutes” for an ambulance to arrive and take him to an ACS site.

“...they knew they can’t do that here [at the hospital], so they phoned ... hospital and arranged for the ambulance; and ambulance came within 20 minutes and took me there; they told me don’t worry, we were looking after you things like that, so I think about 3 o’clock in the morning they operated; I left home about 4 o’clock [in afternoon], it was on the hustle.”

(60 year old man)

- **Condition of roads**

Condition of roads as an external factor that affected patients' level of comfort and length of travel time was mentioned by half of the transferred patients (3 out of 6). They identified "bumpy" city roads with lots of construction as responsible for increased pain and prolonged travel time. A twenty-eight year old woman's story indicated additional movements during the transfer intensified her pain while she was "balancing up and down on the stretcher." Her stories illustrated her unhappiness at a transfer by a Medi-van without any pain management during the transport.

"...so I was transported by Medi-Van down the bumpy construction field road, which wasn't so good when you are in pain;... the conditions on the roads were not really good like I said, and I didn't have any painkillers or any things, and to be balancing up and down on the stretcher and you buckled in by your stomach."

(28 year old woman)

She also perceived her travel time from the original hospital to the ACS site as prolonged due to a road under "construction" and a traffic jam and experienced a high level of anxiety associated with her transfer.

"...It took between I think half an hour to one hour to get there, it was on construction road, so of course the traffic is slower..."

(28 year old woman)

Similarly, a sixty year old man also mentioned that the condition of roads created extra pain and worsened his level of discomfort. However, he acknowledged that the condition of the roads was beyond the control of the hospital and healthcare system.

"...when they went out, sometimes it was bumpy and it hurts because it's all hurting, but they cannot do [anything] it's a road, so."

(60 year old man)

- **Difficulty for patients' family**

Participant stories indicated that transportation to an ACS site not only created some level of discomfort for transferred patients, it also produced a “hardship” for their family members. Patients in the hospital often look forward to visits from family and friends. Two participant stories illustrated that transferring patients to an ACS site outside the patient’s neighborhood was inconvenient for patient’s family and resulted in less frequent and shorter visits. A twenty-three year old woman described how a long distance between her home and the ACS site and a “forty-five minutes drive” to the ACS site made it difficult for her family to come and visit her.

“...I don’t think he [my husband] liked it very much, because the ... hospital is pretty far, I think it takes 45 minutes drive from here, so he’s [pause], like, I never had a choice, so we had to go; ... it was far away from, like from home, so it was harder for my husband and they came and visited me all the time.”

(23 year old woman)

An eighty-one year old man’s story described transfer to the ACS site as “a hardship for the family” which resulted in less frequent and shorter visits, fewer visitors, and diminished familial emotional support.

“I don’t know if this fits in here or not, but it was a hardship for the family ... she, my wife, only got to the hospital to see me once and by the time my daughter were get off the work and get there because of the distance it was about half an hour visiting time left; the ... hospital was a long way from here [my home/neighborhood], it would be much better if a day after surgery they could take you back to the hospital you came from. I don’t know if it would be a problem, I don’t see why it would be; but I don’t know how they manage things... I think it has been done efficiently you know but I feel it was too bad that I couldn’t be transferred back to the ... hospital; I would have more visitors.”

(81 year old man)

- **Risk involved in transference**

Transferring patients to another hospital involves some degree of risk including risks related to the patient’s medical condition and the condition of the roads (Ahmed & Majeed, 2008). However, a majority of transferred patients (5 out of 6) in this study did not perceive any risk

connected to their transfer to an ACS site. Only one participant who had a nursing background perceived some transfer risk related to her medical condition.

“I was scared the most because I had to be transported somewhere else and I know there is also the fact that it could be ruptured any time and they did tell me the safe period is roughly 12 hours, so when three o’clock hits and I was still waiting for my surgery, I was a little bit you know more nervous and you know I felt more flushed, I felt more nauseous right before that of course.”

(28 year old woman)

Communication regarding transfer to an ACS site

Communication regarding transfer to an ACS site emerged as a theme as study participants described their transfer experiences related to two important subjects:

- Informing patients regarding reason for transfer
- Communicating with ambulance staff

• Informing patients regarding reason for transfer

Informing patient regarding the reason for transfer was explicitly mentioned by the majority (4 out of 6) of transferred patients. Participants reported they were notified that the original hospital was not able to perform the operation and that they would be sent to a hospital “where they do the operation.”

“[they explained] that they were going to get an ambulance and transfer me to ... hospital because that’s where they do the operation.”

(53 year old woman-B)

“...once they realized it was gall stones in gallbladder they told me they had to transfer me because they don’t do the surgery.”

(23 year old woman)

An eighty-one year old man described he was being transferred to another hospital “because that is [a place] the surgery would take place, if there’s room to do that.” His story demonstrated that he was informed that his surgery depended on the availability of an operating room and not on his emergency situation.

“I didn’t know for quite a while what [I’m going to be transferred], you know, they sent you for the test and they came back and you wait to hear the results and what they’ve decided to do, and they’re coming and said we are going to transfer you to ... hospital because that’s where the surgery would take place if there’s room to do that.”

(81 year old man)

On the other hand, a forty-seven year old man story indicated that he was not well informed about the main reason for moving him to another hospital; he stated the reason for his transfer to another hospital was “to get some assessment from an expert” since there was uncertainty regarding the need for surgery. He was not notified at the original hospital that surgery was needed and he was being transferred to “where the surgeons are” to perform the surgery. This lack of clear communication and insufficient information created massive frustration and affected his entire acute care surgical experience, since he did not expect to have surgery and assumed further diagnostic tests would be required.

“...the actual transporting me it was all okay; um, but again just the communication, if they’ve told me at the [original] hospital you are going, you need a surgery, we’re going to transfer you over where the surgeons are [pause], you know, but don’t tell me that I’m going to get some assessment from an expert when there’s no assessment is going to happen there, that was the frustrating part. ...they said they are transferring me to the ... hospital because that was where the surgeon, that was where the expert was that could diagnose it; right, so still there was up in the air whether the surgery was required or not.”

(47 year old man)

Participants in the study referred to “they” while they were describing who had informed them about the transfer to an ACS site. This might be the result of having multiple healthcare providers such as physicians and nurses, inform patients about their transfer. Another possibility might be that whomever the patients received information from, did not identify who they were.

- **Communicating with ambulance staff**

Two transferred patients described good communication and friendly interactions ambulance staff provided. This appears have a positive effect on their actual transport experience to an ACS

site. A forty-seven year old man described his actual transportation process by ambulance staff, including lifting him up, loading in the ambulance, bringing to the ACS site, and taking him to a room at the ACS site, was “fine.” He indicated that despite prolonged waiting time for the ride, “transferring from one hospital to the other” was a positive experience. His story illustrated that the friendliness of the ambulance staff and their openness to communication were reasons for his positive perceptions regarding the transfer.

“I guess an example of something that went well was, was just the transferring me from one hospital to the other, other than it took a while for somebody to come, it took 2 to 3 hours for them to be free and come to get me, but the actual transferring me from one hospital to another you know the people were very nice, they asked me some questions and they loaded me up to the ambulance and, um, you know just had generally a positive experience from that group.”

(47 year old man)

An eighty-one year old man felt that friendly conversations with ambulance staff made his transport a “good” experience, despite experiencing an unpleasant transfer on bumpy roads. His stories highlight the important role of the ambulance crew on patient’s perception of their transfer experience to an ACS site.

“The trip from one hospital to the other one was a little bumpy at the time, but on the whole it was good; they looked after me well, and they got me to a bed up in the room ... there were two men that took me, one drove and another one was with me and they said you know if it’s too bumpy let us know, what do you do if it’s too bumpy [chuckled]”

(81 year old man)

Process of admission to an ACS site

The process of admission to an ACS site developed as a theme, as half (3 out of 6) of the transferred patients highlighted how they were admitted to an ACS site. The process of admission to an ACS site described by a number of the transferred participants included being admitted at the ACS site emergency room, having patient information entered into the hospital system, provided with a hospital bracelet, signing consent forms, changing into a new hospital

gown, and ending with a reassessment by a surgeon. Participant stories indicated they had different perceptions about their admissions to the ACS site. It was either:

- Quick and smooth admission
- Time-consuming admission

- **Quick and smooth admission**

Two transferred patients felt the admission to an ACS site was quick and smooth. For instance, a twenty-three year old woman perceived everything at the ACS site was very “quick” since her surgery was performed “right away;” and described her admission process at the ACS site. It started by finding a room for her, getting her dressed in a new hospital gown, and having her assessed by a surgeon.

“ [at the ACS site] they sent me in a room, they found me a room, and then, I had to get dressed in a gown, and then they asked me questions about the pain and what was happening, and then they felt my stomach and they got the result from the ... hospital, my ultrasound, while I was there ... I guess the doctor faxed them, I think they faxed, I’m not sure what they did, but I know they had the results of my ultrasound with them because the surgeon came and talked to me and she said, well, they’ll probably do it later tonight, but [doctor said] I still have to look at your ultrasound result and she came back in, and , oh, no she never came back in, nurse came back in and told me I’m going right away for the surgery; sounds like “oh!” it’s quick.”

(23 year old woman)

An eighty-one year old man also perceived the admission process at the ACS site as fast and efficient. He illustrated his appreciation for the well-organized arrangement at the ACS site by expressing that “they were expecting me apparently.”

“They took me right in [when I arrived at the ACS site]; it didn’t take very long; they were expecting me apparently.”

(81 year old man)

- **Time-consuming admission**

One transferred patient, a twenty-eight year old woman, had a different experience and perceived her admission to an ACS site was time-consuming and frustrating. She described going through the admission process all over again at the ACS site and that waiting in the triage area for “forty-five minutes” delayed her admission. She also stated that a surgeon reassessed her after “at least the four hours span” following her admission to the ACS site.

“...when I got there [at the ACS site] I was waiting by admitting desk in the triage that it took 45 minutes, the lady came I had to sign the papers, they had to give me a new hospital bracelet; then, they had to transport me into my room; once I got there, um, I had to be taken to a different room even though they knew my allergy though that was nice, that needs to be done, that at least took an hour to move me to another room, well I was waiting in hallway, then once they brought me in and got me set up, the doctor finally came and saw me; so, that was at least the four hours span. so, when you think about that as soon as I was rested in that bed after four hours that’s once they slated my surgery; so, of course they were people before that, because I was waiting in a hallway, or waiting for the lady to admit me again; so that took a lots of time.”

(28 year old woman)

In the follow-up focus group, a transferred participant indicated that the findings accurately represented his experiences. He emphasized waiting time for transfer was “too long” from his point of view. He highlighted that the lack of clear “communication at both ends” and the “wait to get the ride” resulted in having a negative experience. On the other hand, he experienced a smooth transfer and admission.

“It looks like you’ve captured my experiences; so generally in my experience it was the waiting time, the wait for the ride was too long in my opinion, and then you’ve captured the experience that I had where I was told that I was going to the hospital to be assessed when in fact I was really brought there to have surgery which was sort of somebody could told me that before I left instead of making me think that I was going for an assessment when actually I was going there to have a surgery; um, yeah, I guess that’s about it. So, really the ride itself was fine, I didn’t mind being transferred per se, and the actual ride over was fine, just sort of communication at both ends and then wait to get the ride were my negative experiences. Regarding the admission, I don’t really remember, I think seems to me they rolled me right in and took me right into a room; so I don’t remember waiting

there once I got there I don't remember any sort of wait I think it seems to me they were actually waiting for me on the floor and they took me on my room; I didn't have any problem there."

(47 year old man)

During the follow-up focus group discussion, a non-transferred participant, a fifty-two year old woman, asked the transferred participant whether his experience in being transferred and gaining the knowledge that not all the hospitals provide emergency services has affected how he might choose medical facilities in future. For example, she said "like if you had another pain would it change where you go to an emergency?"

The transferred patient's answer displays an excellent example of how the consolidated ACSS impacted patient perception of seeking surgical services in the Winnipeg Health Region.

"well, I'm not sure, like if I had, if I go to, say now I have a pain and I'm going to the ... [hospital] because that's where the surgeons are, but then would I have a surgery required that they don't do it at that ... [hospital] they do it at whatever; it seems like for what I can gather is that certain things are handled by certain hospitals and I think no matter which hospital you go to, and I could be completely wrong; but it seems like a "crap shoot", like you just go to the hospital and depending on what issue you get you've been shuffled around the hospitals."

(47 year old man)

His description demonstrated that knowledge and awareness of where to go and how to look for surgical services might be helpful when a patient knows his/her medical issue; however, this information is less important in an emergency situation. He highlighted that gaining knowledge regarding the consolidated surgical services might not affect his decision of where to look for healthcare services and described when he is in pain; he prefers to go to a facility that it is "close" and he is "familiar with."

"...yeah, you diagnose yourself and you know you are having a gallbladder attack, you know that the surgeon are at the ... [hospital], okay, you go to the ... [hospital], or you know you are having a heart attack and you know the heart people are at you know whatever and you drive yourself there, right, so that's

otherwise I'm going to go to the place that I'm familiar with and it's close to me you know, I mean I'm in pain or whatever and I go and just deal with it the best I can, I don't think there is anything

I don't think that I could change anything, like you are in the emergency situation, in acute pain or whatever and just deal with it whatever situation where you are; I don't think that I could have done anything really differently.”

(47 year old man)

Suggestions for Improvement

This section provides participants' suggestions for improving delivery of ACSS in the Winnipeg Health Region. During the interviews, participants were asked three different questions focused on what changes would be helpful to improve ACSS and make the surgical services a better experience.

Participants in this study proposed several suggestions based on their experiences and underlined areas for improvement that the WRHA could improve ACSS through following interventions:

1. Promoting and improving doctor-patient communication
2. Enhancing communications among healthcare professionals
3. Reducing length of waiting time in the ER
4. Extending availability of diagnostic services
5. Providing educational materials such as pamphlets regarding surgical procedures and hospital processes
6. Accelerating transfer processes to an ACS site and improving the admission process at the ACS site
7. Taking a faster approach in responding to nursing call button
8. Providing more emotional support
9. Improving patients' physical comfort by designing more appropriate gowns
10. Providing better quality food

11. Improving public awareness of how and where to seek appropriate healthcare services
12. Hiring “caring staff”
13. Making a telephone follow-up call after hospital discharge

Promoting and improving doctor-patient communication

The most frequent suggestions for improving patient experiences in consolidated ACSS were to improve doctor-patient communication and enhance the quality and duration of patient and healthcare provider interaction.

“I think they just need to spend more time with patients.”

(23 year old woman)

A forty-seven year old man underlined the necessity of improving the communication between surgeon and patient and emphasized how clear and efficient communication should be conducted in a timely manner and with compassion.

“...definitely the communication from the surgical perspective could have been much improved; so the communication to me at ... hospital could have been much better than it was because I spent hours that I was not knowing what’s going on; the communication at the, when I got to the ... hospital[ACS site] from the surgeon could have been much better.”

(47 year old man)

He also expressed his uncertainty regarding how the WRHA could intervene and “influence on how doctors communicate with patients.”

“So, yeah, how could they improve I don’t know, how the Health Authority you know I don’t know what role they play and whether they have any influence on how doctors communicate with patients, um, but that would be the overall, that’s the overall negative experience that I had;improve the communication flows between patients and doctors.”

(47 year old man)

Enhancing communication among healthcare professionals

Study participants strongly suggested that communication among healthcare professionals should be improved.

“...just a better communication between the different groups, between the different doctors really I think, or the communication between the doctor and the patient...”
(47 year old man)

A fifty-two year old woman perceived that healthcare professionals might not have felt responsible enough regarding her medical situation and attributed her post-operative adverse event as a result of lack informational continuity among care providers. Her stories also indicated that clear and attentive communication creates a sense of accountability between healthcare professionals and patients and increases patient confidence and trust.

“Improve? I think the only thing that I think was some kind of the lack of communication, um, because when I came back to the same ward they didn’t really know, or they didn’t tell me what happened; there was lots of guessing but nobody told me why I couldn’t breathe; so I think it’s just lack of communication; sometimes they tell patients a lot of things, but [pause] sometimes I wonder if they felt responsible for not doing something more about when I couldn’t breathe, that’s how I got the feelings, you know what I mean, why they didn’t, someone didn’t respond fast enough for, so I think that’s the feelings that I got that someone was responsible for not acting faster on things and that’s how I, from a few people that they were talking to me, nurses who would change the subject.”
(52 year old woman-B)

Reducing length of waiting time in the ER

Another frequent suggestion for improving patient experience was to reduce ER wait times. A twenty-three year old woman suggested “more doctors in the ER” as a solution to reduce waiting time in ER.

“I think they need to have more doctors in the emergency and not like make them wait so long just get in to see a doctor because if you are really sick or like, it just gets worse in a second and something bad can happen.”
(23 year old woman)

Extending availability of hospital diagnostic services

Several participants suggested that the working hours of the hospital's diagnostic department should be extended to provide timely access to diagnostic services such as ultrasound and CT-scan.

In the follow up focus group one participant underscored all the suggestions mentioned above as explained:

“... if I had to pick one, I guess I really have to pick two [chuckled], if I had to pick two I guess the two would be sort of the one would be the wait times for diagnostic [services] like the ultrasound initially and then wait time in the ER... so just generally the waiting for those two cases and then really just the communication, so the communication in the ER initially and then communication with the surgeon post-surgery were both really lacking. So those are two main suggestions: better communication generally and try to improve the wait time; and the fact that like it kind of shocked me a little bit that I was like the fact I had to wait 5 or 6 days or whatever for the ultrasound.”

(47 year old man)

Providing educational materials regarding surgical procedures

A fifty-three year old woman suggested providing educational materials such as pamphlets regarding surgical procedures as a way to improve communication between patients and doctors. She also mentioned that the “internet” might be a good extra information source to obtain more information regarding surgical procedures, but not for the patients who are in an emergency situation.

“He [doctor] would try to describe what he would going to do, but he didn't describe it in enough detail for me to completely understand; um, so, I did speak to a nurse one time and told her I didn't quite get what he was saying and she tried to describe it better to me, and she did say to me that 'I'm going to look around for a brochure on the surgery', and I guess she never found one because she never brought it to me; but that would be a great idea if they had something like that, like just a pamphlet that a person could read to get all the information they need about what's going to be done to them; if you were at home you could easily go on internet and look up and find out everything, but once it's in the emergency situation, you're in the hospital, there is no internet you just rely on what the nurses

and doctors tell you and if they're doing fill you in enough, there is a lot of like a mystery.”

(53 year old woman-A)

A participant in the follow-up focus group also highlighted the benefits of providing pamphlets to patients regarding the surgical procedures and suggested that the pamphlets could help initiate and further communication.

“I like the idea about maybe some pamphlets I say it would maybe when you are waiting I know the pamphlets are usually very general and vary, but I say it also gives you a point of okay what kind of questions I really need to ask, I mean you are thinking about these things as you are being wheeled onto the, into the OR which guarantee they're never going to discuss with you there. So I say the pamphlet would be a good idea I say it initiates some communication.”

(52 year old woman-A)

Accelerating transfer process to an ACS site and admission process in the ACS site

Several participants suggested that improving patient experience within the consolidated ACSS could be obtained through reducing waiting time for a “ride” to another site and accelerating the transfer and admission at the ACS site. One participant emphasized that transferring patients to an ACS site should be a hospital’s “number one” priority, since most acute surgical procedures are very time sensitive.

“I would say number one, I don't know who can control what surgery had to be done on what hospital and what doctors are on what location, but I mean think about the transportation that took half an hour to an hour to be transported, to get Medi-Van to come and get me that took an hour and half, to set me up and go through whole hospital process again was registering me that took an extra couples of hours, so I assumed that it was serious like an appendectomy that needs to be done right away, that took an extra few hours, so thank goodness when I had a pain I went to the hospital right away because if it was a few hours in between it would have been worse and that's very scary, it could cause an infection and it could be failed as well; so, I would say transportation definitely number one; that needs to be first, if someone is transported, that's emergency because that took an extra few hours for the whole process...It [transportation] should be quicker because when you think of other aspect I mean you have to be admitted again, you have to set up in a room, if that transportation was a little bit quicker that could at least save couples of hours.”

(28 year old woman)

An eighty-one year old man wished that he could have been transferred back to the original hospital in his neighborhood after his surgery at the ACS site to make his surgical experience a better one and more convenient for his family.

“I think the major thing would have been if they could transferred me back to the ... hospital [original hospital close to home] after it was done.”

(81 year old man)

Taking a better approach toward responding to nursing call button

A thirty-five year old woman suggested that nursing staff should take a faster approach to responding to the nurses’ call button.

“...you know you are being paid to provide a service and, um, you know maybe just, I know that everybody there works hard and I had a very good experience, but like I said one of the things that I was disappointed about is that it took so long for them to get to my room.”

(35 year old woman)

Providing more emotional support

A number of participants highlighted the importance of having nursing staff provide emotional support and reassuring patients while they were dealing with anxieties and fears related to their surgery. One participant emphasized “that [providing more emotional support] is something that the Health Authority could look into.”

“I think that they could improve the actual surgical experience, um, maybe just having the nurses working down there, um, realize that most people are going for surgery are scared or terrified, [giggled] you know they have fears, and maybe if they could open their heart up a little bit, um, and, um, be able to be a little bit more comforting, reassuring..., taking somebody’s hand, or giving them a little shoulder rub, or even just looking in their eyes and telling them you know it’s going to be okay, we’re all here, we all know what we are doing, um, I think that would have made a lots of different, good experiences for people because even people they are going and they are tough and in stuff, everybody has fears I mean surgery is not a pleasant thing, so I think that part of the experience, um, could have been changed and I think that is something that the Health Authority could look into.”

(35 year old woman)

Improving patient physical comfort by designing a "proper gown"

A sixty-four year old man creatively suggested a need for designing a proper hospital gown that respects patient privacy and dignity. Suggestions were also made that would enhance its functionality such as better IV access and a pocket for storage.

"...but you know, nothing is perfect, yeah, not too bad, but the gown, I think they have the same gown since around, I don't know how many years you know they should get a gown for today's generation, yeah, fix the gown, just the gown, but everything else was good."

(64 year old man)

Providing better quality food

Improving the quality of hospital food was suggested by several study participants. One participant thought the hospital food was pre-made food and delivered from Calgary. This participant was not happy with the quality of food provided to him during his hospital stay.

"The food [chuckled] you know you don't get anything for a while and then all of the sudden you think oh, this would be good and you lift the lid and [yuck], I just don't understand why they have to I mean they have right facts, but my understanding is that they bring all the food in from Calgary; I had a surgery on my foot at the ... hospital and it was a day surgery but ended up I was later on the day had to go home and I had another meal, so they brought it to me, and I thought before I lift the lid I bet anything is exactly the same thing that my wife's getting at the ... hospital and it was exactly the same meal; and sometimes she would lift the lid and say I'm not eating that [chuckled], I did eat most of it that day, but it just doesn't make sense."

(81 year old man)

Another participant also wished for a better quality food during her hospital stay.

"About the only [pause], I mean if you want to complain I mean it sounds picky, would be the food; I mean I have Celiac disease so this was I get special diet, I mean I've been in a hospital before and the food has been okay, but I mean that would be the only thing I can complain about; I found the food just a little bit on the dry side I say you know, but I mean they did stick to my diet which was good."

(52 year old woman-A)

Enhancing public awareness regarding how and where to seek health care services

Participant stories indicated that there is a need for informing the public about available services in the WRHA and increasing the awareness of the public regarding how and where to seek appropriate health care services.

“I don’t think that I know clearly which hospital in the city to go to in different situations and, um, a ... hospital, I had sort of understood was a type of place to go if you had something like this happened ... I’ve kind of got the impression that if you were having a heart attack in imminent danger that you shouldn’t go to the ... hospital; that was the place in the city to go; ... I figure out that the ... hospital was a right place.”

(53 year old woman-A)

Hiring “caring staff”

The important role that staff serve in a patient’s experience and surgical care was emphasized by all participants. A fifty-two year old woman in response to a question concerning how the WRHA could improve acute care surgical services and make the surgical services a better experience highlighted “making sure that there is good staff have been employed, caring staff”.

“I guess the areas of the concern are more to do with personnel you know the staff; and it so much can depend on the staff that you’re dealing with how good or how bad your experience is; I mean when you’re, you have to have surgery that’s just the fact; you have to have the surgery and you just go through with that; how enjoyable that experience is in, I think, it’s determined a lot by the people that they are around you and the people that are supposed to helping you; so, I think making sure that you know good, there is good staff have employed, caring staff.”

(52 year old woman- B)

Making telephone follow-up after hospital discharge

In the follow-up focus group, one participant described that he was supposed to make an appointment with the surgeon for a follow-up; however, he decided to not do that since “everything was fine” and he felt he does not “need it” and “it seemed to be a waste of time”. His expectation was that “somebody would follow up with him.”

“...okay make an appointment to see surgeon after six weeks and then I chose not to do that; it's no fault to them; it was my choice, I chose not to do that. I would think that somebody would follow up on that, you know, we haven't heard from this guy for two months later and he hasn't called, how come?! you know I would think that somebody would follow up, but nothing, you know a little bit surprised that was like you know certainly my choice that I didn't do that but um, it's a little bit surprised me that nobody would kind of made an effort to kind of ask me or follow up with me ... but just a fact that they raised it when I left and then suggested I do that and I didn't do it, I would think just somebody would have been follow up, that's all.”

(47 year old man)

His description highlight the importance of the follow-up after hospital discharge on both a patient's perception of continuity of care and its effect on patients' confidence in the healthcare system.

CHAPTER FIVE: DISCUSSION

Introduction

This chapter discusses the study findings related to its research questions and compares these findings in relation to the applicable literature. The limitations of this study, noted in chapter three, will be further discussed. Recommendations for improving patient experiences in a consolidated ACSS and suggested directions for future research will also be provided.

The relationship of the findings to the research questions

The purpose of this study was to understand how patients undergoing emergency surgeries including acute appendicitis, cholecystitis, or small bowel obstruction in the WRHA perceived the care provided to them in a consolidated ACSS program. Participants in this study, through their own stories, offered in-depth knowledge regarding what it is like to undergo emergency surgical services in a consolidated ACSS program.

Almost all the participants in this study reported that they were satisfied with the acute care surgical services they received and described mostly positive experiences. The expectation was two participants who described their experiences as generally poor and expressed their dissatisfaction with the overall surgical care provided. Participants' stories indicated that they were not aware of the change in delivery of emergency surgical services in the Winnipeg Health Region; two participants who were transferred to an ACS site mentioned the consolidation of surgical services, but they did not distinguish between emergency and elective surgical services. Transferred participants in this study experienced some difficulties as a result of a transfer to an ACS site including prolonged waiting times, more physical and psychological discomfort, additional pain, and postponed surgical services. However, most of them were happy with the outcome of surgery and acute surgical services they received from an ACS site.

Although most of the patients in this study were satisfied with the overall acute care surgical services they received, they had various perceptions regarding access to surgical services, communication, and safety. These perceptions were not affected by prior knowledge of the consolidation of emergency surgical services within the Winnipeg Health Region. Participants in this study reported that waiting times in emergency rooms and the access to diagnostic services were the main barriers to timely access to emergency surgical services. Transferred patients, in particular, mentioned the time spent waiting for transport to an ACS site as a hindrance to their access to surgical services.

Participants in this study had various experiences regarding communication. Some felt that healthcare professionals communicated clearly and in a timely manner. Others experienced a lack of clear and effective communication during their surgical care process. Transferred patients' stories indicated that communication regarding their transfer to an ACS site could have happened in a timelier manner. Transferred patients had different perceptions regarding the reason for their transfer to an ACS site. Most of the patients in this study felt that the care provided to them occurred in a safe environment. However, a number of participants perceived the potential risk involved in their acute surgical care; one transferred patient experienced some level of risk in her transfer to an ACS site.

In this study, communication, nursing care, access, continuity of care, safety, and transfer were the main factors that shaped patient surgical experiences and their perceptions of quality care in a consolidated ACSS program. These factors will be further discussed in the following section.

Patients in this study had good experiences with acute surgical services with regard to: treatment with compassion and respect by nursing staff, receiving good pain management

particularly in the pre-operative stage and in the emergency room, and friendly interactions with ambulance staff during transfer. However, they wished for better doctor-patient communication, improved communication among healthcare professionals, shorter waiting time in emergency rooms, increased availability of diagnostic services, faster nursing call button response and transfer to an ACSS site, improved physical comfort, increased awareness regarding where to seek appropriate healthcare services, and a telephone follow-up after discharge.

A comparison of the findings to the literature

Eight major themes emerged from the data that describe what patients perceive as significant factors affecting quality of care in a consolidated ACSS. The eight themes were: a) clear and effective communication, b) excellent nursing care, c) timely access to surgical services, d) continuity of patient care, e) patient safety, f) transfer to an ACS site, g) communication regarding transportation, and h) process of admission to an ACS site.

Participants in this study did not rank these factors in any order; however, they most strongly emphasized the importance of clear and effective communication and timely access to surgical services. Although a combination of main factors shaped patients' overall experience as excellent to poor, none of the patients identified all the themes. This might be due to several reasons such as: whether or not they had previous experience in an emergency room or a hospital setting coping with a medical issue, whether they needed to be transferred to another hospital to receive surgical services, or length of hospital stay. Continuity of patient care emerged from the stories of patients who needed to be transferred to an ACS site and had a longer length of stay. Predictably, the themes related to the transfer became visible only in transferred patients' stories.

The themes and sub-categories that emerged from the qualitative data collected in this study are quite similar to those which have emerged from other qualitative studies of patient

experiences with elective surgeries (Henderson et al., 2004), in day surgeries (Barthellsson et al., 2003; Costa, 2001; Gilmartin & Wright, 2008), and in emergency rooms (Gordon et al., 2010). The findings also are in agreement with several components of patient-centered care including access, respect for patients' values and preferences, communication, physical comfort, and emotional support (Balik et al., 2011; The Picker Institute, 2011). The findings also coincide well with some domains of the "responsiveness" concept, including respect for the dignity of persons, prompt attention, and communication (Bleich et al., 2009; World Health Organization, 2001).

Clear and effective communication

Clear and effective communication emerged as a dominant theme in this study. Participants emphasized the significant role of clear and effective communication in contributing to a successful relationship with healthcare professionals and their experiences with acute surgical services. Consistent with the literature, the findings demonstrated that patient experiences in an emergency surgical setting are highly dependent on the quality of healthcare providers' communication and interaction with patients (Gordon et al., 2010; Henderson et al., 2004). When communication is incomplete, unclear, or absent, patients experience fear, confusion, and uncertainty that leads to poor and negative experiences (Bruera et al., 2001).

Patients in this study underlined that good doctor and nurse bedside manner was the primary step toward developing a successful relationship among patients, doctors, and nursing staff, which leads to better communication and an overall positive experience. They also distinguished between nursing staff and doctor bedside manners, as well as communication and interaction with nurses and doctors. Nursing staff's bedside manner constituted the nurse's attitude and tone of voice, and body language. Good doctor bedside manner included: greeting a patient, having a good communication style, and spending sufficient time with the patient. These findings

correspond with other research that studied nurse and doctor communication styles (Rhodes et al., 2004; Williams & Gossett, 2001). For example, Rhodes and colleagues (2004) explored emergency department physician-patient communication through a descriptive study of audio-taped communication among emergency medicine residents and patients in an urban academic medical center. They reported that the emergency medicine residents' communication style was brief; they greeted patients by name only 62% of the time; they introduced themselves by name only 65% of the time; and only 8% of them indicated their status as residents in training. Although their communication often began with an open-ended question, they did not allow patients to complete their response; they often interrupted them shortly after patients described their main complaints. The information provided to patients was mostly (88%) about tests or expected procedures during the ED visit (Rhodes et al., 2004).

Doctors' and surgeons' ability to explain surgical procedures in a way that allows patients to understand clearly was highlighted as another important factor in doctor-patient communication. With effective communication, patients felt that they had been involved in decisions for their treatment. This finding is consistent with the literature emphasizing the importance of communication as a core competency in medicine, since the communication skills used in the exchange of the information directly impacts the patient-physician relationship, patient involvement in care, and satisfaction with quality care (Rodine et al., 2009; Street et al., 2005).

Effective nurse-patient communication was described as providing information regarding the entire process of surgical care, acknowledging patient's feelings and anxiety, advocating for the patient, and clarifying surgeons' explanations. Participants in this study mentioned they felt better supported, gained a deeper understanding of what was happening to them, and were less fearful of their surgical experience through an effective interaction and communication with

nursing staff. These findings align with literature that identifies nursing staff's communication skill as having an important impact on patient perceptions of quality care and surgical experiences (Blockley & Alterio, 2008; Williams & Gossett, 2001).

A number of participants in this study felt that the nursing staff did not communicate with patients actively and perceived that the focus of the nursing staff was on their clinical tasks while providing care, not on communication with patients. This finding coincides with the findings of a phenomenological study, which explored patient experiences with nursing communication and reported that some patients perceived a lack of communication from nursing staff as they felt nurses were more concerned with doing their work than communicating with them personally (McCabe, 2004).

Provision of timely and sufficient information was the main component of effective communication on patient experiences with acute care surgery. Timely and sufficient information, mostly facts regarding the process of acute care and the surgical procedure presented in a way that is transparent and understandable, assisted in reducing patients anxiety associated with the surgical experience. Participants in this study reported that the lack of timely information led to psychological distress, confusion, and misunderstandings for them. The provision of information has been reported in empirical literature as one of the main factors influencing patient experiences with surgical care and within emergency departments (Costa, 2001; Gordon et al., 2010; Henderson et al., 2004, Taylor & Benger, 2004). A systematic review of qualitative research in patient experiences within emergency departments reported that patients were appreciative when information given to them was understandable and provided in a consistent manner. Patients had a desire for more information on all aspects of care, including

both verbal and written (Gordon et al., 2010). The literature also identified that patients experience increased anxiety when they do not know what to expect next (Costa, 2001).

In accordance with the literature indicating that care providers are a primary source of information for patients in surgical settings (Baly & Donoghue, 2006), participants in this study appreciated the information provided through face-to-face conversation with emergency room doctors, surgeons, and nurses. They also requested written information such as pamphlets regarding their surgical procedure and the hospital process. Pamphlets serve as an additional source of information to help patients better understand their surgical experience and enhance communication with care providers. This finding is consistent with other studies that identified written information such as pamphlets as a helpful source of information for patients undergoing surgery (Baly & Donoghue, 2006; Gillies & Baldwin, 2001). Baly & Donoghue (2006) in their survey study of information provided to patients scheduled for laparoscopic cholecystectomy (LC) surgery identified that patients preferred to receive health information by direct contact with health professionals (35%) as well as printed literature (33%). They reported that printed literature including a “LC leaflet” was a beneficial source of information, particularly on pain management practices. Other additional sources of information identified by the patients were the internet and medical books (Baly & Donoghue, 2006). Another survey study assessing patient attitudes toward receiving a patient information booklet “Anaesthesia and Anaesthetists - Information for Patients and Relatives” prior to their surgery in a preadmission clinic, reported that 99% of patients found the information provided in the booklet as useful. At the same time, 35% of patients stated that the information in the booklet increased their anxiety. The authors of the study concluded that written information should be provided in appropriate form to avoid increasing patient anxiety (Gillies & Baldwin, 2001). Receiving written information regarding

the surgical procedures and hospital processes is beneficial to acute surgical patients while they are waiting for their surgery or to be transferred to an ACS site.

The importance of clear and effective communication was highlighted by participants in this study. This communication mostly referred to the attitude, behaviour, and compassion of healthcare professionals along with the provision of timely and sufficient information. These findings coincide well with the “dignity conserving care model” principles which describe attitude, behaviour, compassion, and dialogue as “the core value of medical professionalism” (Chochinov, 2007). This framework offers clinicians a straightforward guideline to providing more compassionate and respectful care for patients (Chochinov, 2007) and demonstrates a high capacity to improve communication skills among healthcare professionals.

In the ABCD framework for “dignity conserving care,” “A” stands for “attitude” and suggests that healthcare providers should examine their attitudes and assumptions toward patients and acknowledge that their assumptions may not be based on a patient’s reality. “B” stands for “behavior” and suggests that awareness of attitudes can lead to modified behaviour in a manner that recognizes a patient’s needs. Certain approaches in clinical examination and communication with patients, such as asking a patient’s permission prior to performing a physical examination and the inclusion of trainees in the clinical examination, providing information in a way patients understand, repeating the information and explanation as per patient and family requests, and encouraging patients to ask questions sustains the respect and acknowledgment of a patient’s personhood. “C” stands for “compassion” and refers to a deep awareness of the suffering of another, along with a wish to relieve that suffering. “An understanding look,” “a gentle touch on the shoulder, arm, or hand,” and acknowledging patients as persons are ways to present compassion. Finally, “D” stands for “dialogue” and underscores

the importance of conversations that allow healthcare providers to acknowledge issues of personhood and to know patients beyond their illness. The A, B, C, and D of “dignity conserving care” provides comprehensive guides that could easily be adopted to providing care and teaching in many healthcare settings (Chochinov, 2007) including surgery.

Excellent nursing care

Nursing care was another key determinant of patient experiences and perceptions of quality of ACSS identified by participants. The majority of patients in this study appreciated nursing staff who took an interest in their wellbeing and provided care with compassion and respect, listened to them, spent time with them, and talked to them as individuals. They also acknowledged nursing staff who addressed their needs quickly and described their experiences related to the impact of quick responses to the nursing call button. Immediate attention to patient needs affected patient perceptions of high quality nursing care and increased their feelings of comfort and security. Lack of a speedy response to the nursing call button was perceived as neglect and abandonment. These findings are consistent with previous studies reporting that the best aspects of patient experiences with nursing care were a caring atmosphere where nursing staff listened to the patient, perceived them as an individual, and responded in a timely manner (Ahmmad & Alasad, 2004; Block & Alterio, 2008).

The findings from this study indicated that reducing anxiety, alleviating pain, and controlling vomiting and nausea, in addition to improving environmental conditions, enhances the quality of patient experiences. In agreement with literature that indicates a high level of anxiety among surgical patients (Barthelsson et al., 2003; Costa, 2001; Gilmartin & Wright, 2008), participants in this study described experiencing extreme anxiety in relation to entering the operating room, seeing surgical instruments, going under anesthesia, expecting post-operative pain, and very

worried about surgical risk. A number of participants also commented on experiencing anxiety as a result of not eating solid food following the operation. This further highlights the importance of physical comfort and provision of emotional support in reducing patient anxiety.

The importance of managing patient pain in the pre-operative and post-operative stages has been well documented in the literature (Chavis & Duncan, 2003; Kamming et al., 2004; Sherwood et al., 2003). In this study, patients stated that alleviating and controlling pain in a timely matter, particularly in the emergency room and prior to surgery, had a very important impact on their experiences with acute surgical services. Appropriate pain management improved patients' physical comfort and decreased patients' perception of waiting time in the pre-operative stage. Some participants in this study described their postoperative pain as well managed; they were satisfied using patient controlled analgesia pumps. This finding contrasts with Costa's (2001) study that reported patients experienced inadequate pain management following same day discharge of their abdominal surgery (Costa, 2001). A number of studies have identified that the provision of effective pain management post-operatively was inadequate among patients who underwent ambulatory surgical surgeries (Kamming et al., 2004; Rocchi et al., 2002). A survey study of Canadian post-operative pain and pain medication experiences reported that while 68% of inpatients and 49% of outpatients experienced pain in the surgical facility, they experienced more pain in the two weeks following discharge (79% and 74% of inpatients and outpatients, respectively). Although, 65% of inpatients and 72% of outpatients who took pain medication reported "complete or a lot of pain relief" in the surgical facility, almost all of them (90% inpatients and 97% outpatients) were satisfied with the pain medication they received (Rocchi et al., 2002). Patient satisfaction with pain management is beyond analgesic efficacy and also depends on patient expectations, education, personal preferences,

communication with healthcare providers, and the overall care provided (Rocchi et al., 2002; Sherwood et al., 2003). Educating patients pre-operatively and providing both verbal and written information on how the pain is managed post-operatively and how to manage their pain after discharge enhance the outcome of pain management (Sherwood et al., 2003).

Many participants in this study reported suffering from nausea and vomiting prior to their surgery. They appreciated the nursing staff for providing appropriate care, which alleviated these symptoms. They did not report any symptoms of nausea or vomiting following their surgery. This finding differs from Barthelssen and colleagues (2003) that indicated patients who underwent laparoscopic cholecystectomy in the day surgery experienced nausea and vomiting post-operatively (Barthelssen et al., 2003).

In contrast with previous research, which identified discharge from the hospital as a dominant factor in patient experiences (Barthelssen et al., 2003; Henderson et al., 2004), the findings of this study did not show discharge as a critical factor in patient experiences with the ACSS, even though a few participants mentioned their discharge. The reason for this discrepancy cannot be established as patients were not encouraged to discuss this in regard to the research questions.

The findings of this study highlight the importance of facilitating patients' physical comfort through enhancing the hospital environment including room temperature, light, noise levels, ventilation, providing an appropriate gown, and improving the quality of food. These findings are in agreement with another qualitative study that identified "hotel services" as the most important factor in patient experiences and their perception of a satisfactory hospital stay (Henderson et al., 2004).

Timely access to surgical services

The findings of this study indicate that patient satisfaction with emergency surgical services is closely related to the impact of waiting time in the emergency room and to accessing diagnostic services. The majority of patients described waiting to receive services as a source of “frustration.” While a few participants experienced fast service and prompt admission to an emergency room, several other patients acknowledged that waiting time in the emergency room is unavoidable and the length of waiting time in the emergency room depends on the patient’s level of triage and the level of crowding in the emergency room. These findings are consistent with other literature, which identified waiting times as an important factor in patient experiences (Gilmartin & Wright, 2008; Gordon et al., 2010; Henderson et al., 2004). Gordon and colleagues (2010), in a systematic review of qualitative studies of patient experience within the emergency department, identified that waiting was one of the most influential factors in patient experiences and included a broad spectrum of factors, such as waiting for initial physician assessment, waiting to go for a diagnostic test, and waiting for test results. Patients indicated that patient experience is not solely dependent on length of time, but also associated with information given to patients, physical comfort, and interaction with healthcare professionals during the period of waiting (Gordon et al., 2010). A phenomenological study reported that patients felt “miserable, abandoned, and upset” during the preoperative wait. They were mostly upset with long waiting times prior to their surgery and not receiving any information about the delay (Gilmartin & Wright, 2008). In another qualitative study, “time to wait for care” was identified as one of the important themes that affected patient satisfaction and hospital stay experiences. Patients in this study referred to “time” in two contexts: time spent undergoing care and time waiting to receive care (Henderson et al., 2004).

Psychological factors such as anxiety, uncertainty, and pain influence patient experiences with, and perceptions of, waiting time. Perceived waiting time for patients who are in pain and anxious is much longer than actual waiting time. One participant voiced this by describing “waiting time in an emergency room could be 6 to 8 hours which means for somebody who is in pain like 6 or 8 DAYS.” These findings are in agreement with previous research that identified the relationship among expectations, perceived waiting time, and satisfaction with waiting for patients seeking emergency services (Boudreaux & O’Hea, 2004; Cassidy-Smith et al., 2007; Thompson et al., 1996).

The findings of this study underlined the role of communication as a key factor influencing overall patient experiences and perceived waiting times. Communicating with patients while they are waiting to receive care reassured them that they were not forgotten and reduced uncertainty and stress associated with waiting. This corresponds with other studies that established that communication mitigates negative effects of long waiting times and improves perceived waiting time by patients (Boudreaux & O’Hea, 2004; Soremekun et al., 2011).

The availability of diagnostic services was another major factor that affected patient experiences and their perceptions of access to acute surgical services. Unavailability of diagnostic services such as ultrasound during the evening shifts and weekends had a negative impact on patient experiences. The findings of this study indicate that extending availability of diagnostic services or providing 24 hour access to essential diagnostic services such as ultrasound, regardless of the cost-effectiveness of these initiatives, has a tremendous impact on patient experiences within a consolidated ACSS.

A number of participants in this study expressed that the lack of diagnostic services in the evening, early morning, and weekends was undesirable, creating a high level of anxiety and a

poor experience. This finding is in agreement with the results from the Health Services Access Survey that measured acceptability of waiting times and the burden of waiting for care including specialist visits, non-emergency surgery, and diagnostic tests among the Canadian public. Twenty-one per cent (21%) of patients who answered the survey felt that their waiting time for diagnostic tests was unacceptable, twelve per cent (12%) indicated that waiting for diagnostic services affected their life by creating stress and anxiety (2/3) and experiencing pain (1/3) during the waiting period (Sanmartin et al., 2006).

Continuity of patient care

Continuity of patient care relates to consistent, connected, and coherent care provided to a patient over time. Continuity of care is distinguished from other attributes of care by two core elements: care provided to a patient over time and care focused on the individual patient. Continuity of patient care is described as coordination of activities and sharing of medical information among healthcare providers structured into: informational continuity, relational continuity; and management continuity (Reid et al., 2002).

Participants in this study indicated that continuity of patient care, including interpersonal and informational continuity, was an important aspect influencing their surgical experiences. A number of them perceived that interpersonal continuity as well as informational continuity, was lacking to some extent during their post-operative care.

In a hospital setting, continuity of patient care has been described as the ability to identify who has an ongoing responsibility for the care of a patient throughout a given admission (Reid et al., 2002). Continuity of patient care in this study was described by participants as a consistent relationship with the same surgeon who performed their surgery during their post-operative stay in the hospital. This finding supports the findings of another qualitative study that identified

continuity of care as a continuous meeting with the surgeon who performed the surgery (Barthelsson et al., 2003).

The findings of this study indicate that patients, especially those who stay in the hospital for a short period of time, not preferred to receive care from different groups of surgeons. Receiving care from different rotational ACS teams created high levels of discomfort and frustration. This corresponds with other studies which identified, that despite increased demands and interest in the healthcare system for providing care through a group of doctors, and in shifting continuity of care from single doctor-patient to team-based relationships, patients preferred to have an interpersonal relationship with a single doctor (Pandhi & Saultz, 2006; Pereira & Pearson, 2003). Concentrating patient care among a limited number of healthcare providers develops a trusting relationship and supports a mutual understanding among patients and care providers (Adler et al., 2010; Pandhi & Saultz, 2006), ensuring high quality and safe care.

Patient safety

Health care interventions are planned to benefit patients; however, interventions also involve the risk of adverse events. These risks result from a “complex combination of processes, technology, and human interactions” (World Health Organization, 2002, p.1) and may lead in disability, long hospital stay, or death (Baker et al., 2004). The adverse event rate in Canadian acute care hospitals is reported as 7.5 per 100 hospital admissions, with 36.9 per cent of these adverse events considered preventable. The most common type of adverse event reported relates to surgical procedures (34 per cent), followed by drug or fluid-related event (23.6 per cent), other clinical management (12 per cent), and diagnostic procedures (10.5 per cent) (Baker et al., 2004).

The findings from this study indicate that potential medication error or post-operative adverse events, such as postoperative wound care, often resulted from lack of effective

communication with patients as well as among healthcare professionals. This aligns with previous research that identified effective communication as a key element in providing safe care (Sutcliffe et al., 2004; The Joint Commission on the Accreditation of Health Care Organizations, 2009). Sutcliffe and colleagues (2004) examined individual resident's experience and perception of the causes and contexts of medical mishaps through a series of 26 semi-structured interviews. They reported that "faulty communication" was the main contributor to the majority of medical errors and adverse outcomes for patients experienced by residents. They also found that communication breakdown was not only a result of poor transmission or exchange of information, but was also related to "hierarchical differences, concerns with upward influence, conflicting roles and role ambiguity, and interpersonal power and conflict." These socio-structural effects were most likely to occur in relationships between residents and attending physicians, residents and other specialists, and residents and nurses.

In agreement with literature related to patient safety (Baker et al., 2004; Gilmour 2006; Morris-Donovan et al., 2008; Zhan & Miller, 2003; World Health Organization, 2002), patients who experienced an adverse event or potential medication error had poor perceptions of quality of care, lost their confidence in healthcare providers, and experienced a prolonged recovery. Therefore, enhancing patient safety through various initiatives is critical in ensuring high quality care, rebuilding a sense of trust in care providers, and reaffirming patient confidence in the healthcare system.

Transfer to an ACS site

The findings of this study contribute to the literature an understanding of the importance of inter-hospital transfer on patient experiences in a consolidated ACSS. Participants in this study had different perceptions regarding their transfer. Several of the transferred patients perceived

that they did not have a “choice” and “accepted” the situation. One participant perceived his transfer as a privilege; he assumed he was accessing better surgical services. Other transferred patients found that transfer to an ACS site was strange, alienating, and annoying. One participant felt that the transfer to an ACS site was the worst part of her surgical experience in the consolidated ACSS. She described the transfer as amplifying her level of discomfort and stress. This finding is consistent with literature that identified inter-hospital transfer as one potential source of patient anxiety and pain (Ahmed & Majeed, 2008; Dunn et al., 2007).

Transferred participants described their relocation to an ACS site either by ambulance or Medi-van; however, their stories did not clearly indicate whether different vehicle choice was related to vehicle availability or severity of their medical condition. Participants in this study perceived a Medi-van as a vehicle for transferring non-urgent patients. This is in agreement with a study conducted by Kreindler and her colleagues (2011) that indicated all transferred patients did not travel by ambulance in a consolidated ACSS program. The status also indicated that ambulance transfers took about an hour less than non-ambulance transfers and 25% of non-ambulance transferred patients experienced delays on their way to an ACS site (Kreindler et al., 2011).

The findings of this study demonstrate that patient experiences in a consolidated ACSS were closely related to waiting times for transport. Transferred patients had different perceptions regarding the length of waiting time for transport. They described it in relation to other factors, including how long they previously waited in an ER and how they perceived the severity of their medical condition. Although the perceived waiting time for two transferred participants was short, several transferred patients experienced a long waiting time before a vehicle arrived. This extra waiting time affected the patient’s experiences negatively and created increased levels of

anxiety and perceived complexity of the process. This finding is consistent with the results of a recent quantitative study (Kreindler et al., 2011), which found that transferred patients in a consolidated ACSS had longer wait times than non-transferred patients. This study also indicated the average length of transfer was two hours, only 40 minutes of which was spent in actual travel time (Kreindler et al., 2011).

Previous research indicates that many factors are associated with safe, effective, and timely transportation. These include appropriate vehicle and equipment, experienced staff, patient's medical condition, environmental conditions, and hospital transportation strategies (Dunn et al., 2007; Wallace & Ridley 1999). Transferred patients in this study recognized road conditions and traffic jams as external factors that affect timely transfers; however, none of the transferred patients referred to weather conditions as a factor that might influence a fast and safe transfer. The data for this study was collected during the summer and early fall which might be a reason for not referring to weather as a factor in safe and timely transfer as winter weather is more likely to affect road conditions than other seasons.

Evidence in the literature indicates that inter-hospital transfers carry modest potential risk (Ahmed & Majeed, 2004). In this study, one participant perceived some degree of risk regarding her medical condition during the transfer; however, the majority of transferred patients did not perceive any risk involved in their transfer.

The findings of this study indicated that transfer to an ACS site far from the patient's neighborhood created a further difficulty for patients, as well as their family. Such transfers resulted in reduced visits from family and friends. Several patients in this study preferred to receive their care closer to their home. This finding is to some extent in agreement with a comparative study of secondary data from different studies undertaken in Norway, Denmark, and

Sweden, which analyzed how patients choose between hospitals in integrated public health systems with universal coverage. This study reported that while many patients are aware of their right to choose the location of their health services, relatively few patients actively chose their healthcare facility. The short distance to a hospital along with hospital reputation and waiting time were important factors for choosing a healthcare facility (Vrangbaek et al., 2007).

Communication regarding transfer to an ACS site

The important role of communication in transferring patients to another hospital has been documented in the literature. Communication in this regard refers to verbal, non-verbal, and written dissemination of information among hospital staff, the transfer team, and the receiving hospital (Dunn et al., 2007; Murray et al., 2011). The findings of this study indicate that one essential component of communication involves informing patients about the necessity of their transfer. The findings illustrate that receiving timely, straightforward, and clear information regarding the reason for their transfer was an important factor in patient overall experience within a consolidated ACSS program.

Communicating with patients regarding their medical condition and offering a clear explanation of the need for transfer, along with reassurances about their safety reduce patient anxiety and enhance patient experiences. Some participants in this study appreciated the friendliness of ambulance crews and emphasized that this positive communication made their actual transport to an ACS site a positive experience.

Process of admission to an ACS site

The findings of this study indicate that the process of admission to an ACS site was another factor that influenced transferred patients' acute surgical experiences. A number of participants

perceived that their admission to an ACS site was well-organized and fast. However, one patient experienced a time-consuming admission process and a long waiting time in the emergency room after her arrival at an ACS site. This affected her transport experience negatively. Kreindler and colleagues (2011) found that many transferred patients were admitted directly to an ACS site. By bypassing the emergency room, these transferred patients did not experience any prolonged waiting periods (Kreindler et al., 2011).

The findings of this study suggest that an appraisal of the admission process in ACS sites for transfer patients is likely to be beneficial. Referring hospitals and ACS sites should ensure direct admission for transferred patients at the ACS sites and eliminate readmission of transferred patients through emergency rooms. Transportation of patients who require emergency surgical services is inevitable in a consolidated ACSS program. Therefore, providing effective, safe, and timely transport, along with prompt admission after arrival at an ACS site, is essential to develop positive experiences for transferred patients.

Limitations of the study

Small sample sizes often used in qualitative research typically raise concerns about the generalization of the findings. However, the purpose of the present study was not to generalize the findings. The primary aim of this study was to understand how patients experienced acute surgery in a consolidated system and to explore a range of factors influencing their surgical experiences.

The application of an appreciative inquiry (AI) framework in this study, which focused on learning from successes and building upon the best of what is in a system, offered mostly positive patient experiences. However, applying this approach did not dismiss poor patient experiences.

In this study, the discovery phase of the AI process was mainly used in designing the semi-structured interview guide, collecting, and analyzing the data. The researcher conducted face-to-face interviews and maintained neutrality. This is in contrast to common appreciative interview techniques which involve interviews conducted in pairs with participants sharing their stories. Applying a complete AI process including discovery, dream, design, and destiny may have benefited the study and the surgical program. Appreciative Inquiry (AI) approach may have added to the richness of the interviews, data collection, and analysis by providing further insight into both patient experiences, as well as gaps in the system.

This study was conducted by a novice qualitative researcher who developed the interview guide and conducted all interviews. Implementing strategies such as ongoing review of the transcripts and involving the expertise of a committee member during the data analysis stage minimized potential bias.

Despite the limitations of this study, the findings provide insight into the perspectives of thirteen patients who underwent emergency surgeries. The findings can serve as an introduction to the role of ACSS consolidation in delivering surgical services.

Recommendations and Implications

The findings of this study illuminate possible pathways to enhancing patient experiences. Acute care surgical services can be improved by concentrating on enhancing the main domains of experience as identified by the patients and incorporating the following suggested directions for future research.

Implications for improving patient surgical experiences

The importance of *improving communication* between patient and care provider, as well as among healthcare professionals, was emphasized by patients in this study. The findings of this

study suggest applying the “dignity conserving care model” (Chochinov, 2007) into clinical practice should improve healthcare professionals’ interactions and communication with patients and enhance patient experiences in a surgical setting.

This study reveals the importance of informing patients and their family members about medical condition in a timely and ongoing manner. It would similarly be valuable to develop a patient care guide in order to better inform patients and their family members about the process of surgical care or the need for a transfer to an ACS site in the consolidated ACSS.

The findings of this study suggest *expanding the availability of diagnostic services*, including ultrasound, in non-referral hospitals to reduce surgical waiting times for transferred patients.

According to the findings in this study, *alleviating patient pain*, improving patient *physical comfort*, and communicating with patients shortens patient perceived waiting times. Addressing these issues while the patient is in the emergency room, and/or being transferred to another facility enhances patients’ overall experience.

Patients’ concern regarding the *continuity of care* in a consolidated ACSS suggests that developing a better hand-over strategy among ACS surgeons, and possibly, reviewing and reconsidering the rotation scheduling of ACS teams may be a valuable approach to improving patient experiences.

As a strategy to reduce transferred patients’ surgical wait times in a consolidated ACSS, *direct admission to an ACS site* for transferred patients should be implemented in all ACS sites. To ensure the success of implementing this policy, all parties including referral hospitals, transfer teams, and ACS sites should be clearly informed about the purpose of this policy.

Written materials such as pamphlets about the most common acute surgical procedures and the overall hospital process should be developed and offered to patients.

Findings of this study revealed that potential medication errors could have occurred. Since potential medication errors are not recorded in medical charts or incident reports, it is difficult to identify and prevent them. Telling stories about potential medication errors might be an effective approach to developing a successful patient safety strategy, protecting patients from injuries that might result from medication error, and enhancing quality of care in healthcare organizations.

Implications for future Research

The focus of this study was only on patient experiences in consolidated acute care surgical services and not on elective surgical services. This study did not include the voice of patient family members or healthcare professionals including surgeons and nurses. These areas would be beneficial directions for future research to provide a better understanding of the impacts of consolidated surgical services.

Conclusion

This qualitative study has provided an in-depth understanding of patient experiences in a consolidated ACSS program and identified notable factors that influence patient experiences. The findings of this study illustrate that despite overall satisfaction with acute care surgical services, patients in this study had varied experiences in relation to their interaction and communication with care providers, timely access to surgical services, and perception of receiving care in a safe environment. The findings of this study inform policy makers, surgery program managers, and healthcare professionals about patient experiences of regionalized acute care surgical services and provide suggestions for improving patient experiences and the future planning and development of acute surgical services.

REFERENCES

- Adler, R., Vasiliadis, A., Bickell, N. (2010). The relationship between continuity and patient satisfaction: a systematic review. *Family Practice*, 27(2), 171–178.
- Ahmad, M.M., & Alasad, J. A. (2004). Predictors of patients' experiences of nursing care in medical-surgical wards. *International Journal of Nursing Practice*, 10(5), 235-241.
- Ahmed, I., & Majeed, A. (2008). Risk management during inter-hospital transfer of critically ill patients: making the journey safe. *Emergency Medicine Journal*, 25, 502-505.
- Aspden, P., Corrigan, J.M., Wolcott, J., Erickson, S.M., Editors, Committee on Data Standards for Patient Safety. (2004). *Patient safety: achieving a new standard for care*. Washington, DC: National Academies Press. Retrieved on April 16, 2011 from www.nap.edu
- Austin MT, Diaz JJ, Jr., Feurer ID, Miller RS, May AK, Guillamondegui OD, et al. (2005). Creating an emergency general surgery service enhances the productivity of trauma surgeons, general surgeons and the hospital. *Journal of Trauma*, 58(5), 906-910.
- Baker, G. R., Norton, P.G., Flintoft, V., Blais R., Brown, A., Cox, J., Etchells, Ed., Ghali, W.A., Hébert, P., Majumdar, Sumit R; O'Beirne, Maeve; Palacios-Derflingher, Luz; Reid, Robert J; Sheps, Sam; Tamblyn, Robyn. (2004). The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. *CMAJ*, 170(11), 1678-1686.
- Balik, B., Conway, J., Zipperer, L., & Watson, J. (2011). Achieving an exceptional patient and family experience of inpatient hospital care. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement. Available online at: www.IHI.org
- Ball, C.G., Hameed, S.M., Brenneman, F.D. (2010). Acute care surgery: a new strategy for the general surgery patients left behind. 2010 Canadian Medical Association, *Canadian journal of surgery*, 53(2), 84-85.
- Barthelsson, C., Lützén, K., Anderberg, B., & Nordström, G. (2003). Patients' experience of laparoscopic cholecystectomy in day surgery. *Journal of Clinical Nursing*, 12, 253–259.
- Bertazzoni, G., Cristofani, M., Ponzanetti, A., Trabalzini, A., Attalla, H., De Vito, C., & Villari, P. (2008). Scant justification for interhospital transfers: a cause of reduced efficiency in the emergency department. *Emergency Medicine Journal*, 25(9), 558-61.
- Bhagvan, S., & Civil, I. (2009). Acute care surgery: can New Zealand afford to wait? *The New Zealand Medical Journal*, 122 (1289), 71-76.
- Blay, N. & Donoghue, J. (2006). Source and content of health information for patients undergoing laparoscopic cholecystectomy. *International Journal of Nursing Practice*, 12, 64-70.

Bleich, S.N., Ozaltin, E., Murray, C.K. (2009). How does satisfaction with the health-care system relate to patient experience? *Bulletin of the World Health Organization*, 87(4), 271-278.

Blockley, C., & Alterio, M. (2008). Patients' experiences of interpersonal relationships during first time acute hospitalisation. *Nursing Praxis in New Zealand Inc.*, 24(2), 16-26.

Boudreaux, E.D., & O'Hea, E.L. (2004). Patient satisfaction in the Emergency Department: a review of the literature and implications for practice. *The Journal of Emergency Medicine*, 26(1), 13-26.

Bowen S. (2006). Learning from patient experiences: strategies for obtaining patient input (concept paper). Winnipeg Regional Health Authority.

Britt, R.C., Weireter, L.J., Britt, L.D. (2009). Initial Implementation of an Acute Care Surgery Model: Implications for Timeliness of Care. *Journal of the American College of Surgeons*, 209, 421- 424.

Bruera, E., Sweeney, C., Calder, K., Palmer, L., & Benisch-Tolley, S. (2001). Patient preferences versus physician perceptions of treatment decisions in cancer care. *Journal of Clinical Oncology*, 19(11), 2883-2885.

Canadian Association of General Surgeons. (2009). The Acute Surgery and Critical Care Committee. Available online at: www.cags-accg.ca/index.php?page=228

Cassidy-Smith, T.N., Baumann, B.M., Boudreaux, ED. (2007). The disconfirmation paradigm: throughput times and emergency department patient satisfaction. *The Journal of Emergency Medicine*, 32(1), 7-13.

Charmel, P.A., & Frampton, S.B. (2008). Building the business case for patient-centered care. *Healthcare Financial Management*, 62(3), 80-85.

Chavis, S.W., & Duncan, L.H. (2003). Pain management--continuum of care for surgical patients. *AORN Journal*, 78(3), 382-6, 389-99, quiz 400-1, 403-4.

Chochinov, H.M. (2007). Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. *British Medical Journal*, 335, 184-187.

Chow, A., Mayer, E.K., Darzi, A.W., & Athanasiou, T. (2009). Patient-reported outcome measures: The importance of patient satisfaction in surgery. *Surgery*, 146 (3), 435-443.

Coghlan, A.T., Preskill, H., Catsambas, T.T. (2003). An Overview of Appreciative Inquiry in Evaluation. *New Direction for Evaluation*, 100, 5-22.

Collis, J. (2010). Adverse effects of overcrowding on patient experience and care. *Emergency Nurse*, 18(8), 34-39.

Connor, H. (2002). The changing face of acute medicine. *Clinical medicine: journal of the Royal College of Physicians of London*, 2(4), 287-289.

Cooperrider, D.L., Whitney, D., Stavros, J.M. (2008). *Appreciative inquiry Handbook for leaders of change* (2nd Edition). Crown Custom Publishing, Inc.

Cooperrider, D.L., & Whitney, D. (1999). *Appreciative inquiry. Collaborating for change*. Berrett-Koehler Communications, Inc.

Cooperrider, D.L., & Whitney, D. (2005). *Appreciative inquiry: a positive revolution in change*. Berrett-Koehler Publisher, Inc.

Costa, M.J. (2001). The lived perioperative experience of ambulatory surgery patients. *AORN Journal*, 74(6), 874-881.

Creswell, J.W. (2007). *Qualitative inquiry and research design: choosing among five approaches*. (2nd Edition). SAGE Publications, Inc.

Creswell, J.W. (2009). *Research design: qualitative, quantitative, and mixed methods approaches*. (3rd Edition). Los Angeles: SAGE Publications, Inc.

Darzi A. (2008). High quality care for all. NHS next stage review final report. Department of Health. London. Retrieved May 2011 Available online at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalasset/dh_0858

Division of Advocacy and Health Policy. (2006). A growing crisis in patient access to emergency surgical care. *Bulletin of the American College of Surgeons*, 91(8), 8-19.

Dougall, A., Russell, A., Rubin, G., & Ling, J. (2000). Rethinking patient satisfaction: patient experiences of an open access flexible sigmoidoscopy service. *Social Science and Medicine*, 50(1), 53-62.

Dunlap, C.A. (2008). Effective evaluation through appreciative inquiry. *Performance Improvement*, 47, 23–29.

Dunn, M.J.G., Gwinnutt, C.L., Gary, A.J. (2007). Critical care in the emergency department: patient transfer. *Emergency Medicine Journal*, 24, 40-44.

Dunsford, J. (2009). ACSS Evaluation – Grace Hospital Site. Unpublished report. Internal evaluation report, Grace Hospital, Winnipeg Regional Health Authority.

Earley, A.S., Pryor, J.P., Kim, P.K., Hedrick, J.H., Kurichi, J.E., Minogue, A.C, et al. (2006). An acute care surgery model improves outcomes in patients with appendicitis. *Annals of surgery*, 244(4), 498-504.

Epstein, R.M., Fiscella, K., Lesser C.S., & Stange, K.C. (2010). Why the nation needs a policy push on patient-centered health care. *Health Affairs*, 29(8), 1489-1495.

Faryniuk, A., & Hochman, D. (2009). Effect of an acute care surgical service on the timeliness of care. Unpublished report. St. Boniface General Hospital, Winnipeg Regional Health Authority.

Ferner, R.E., & Aronson, J.K. (2006). Clarification of terminology in medication errors. Definitions and classification. *Drug Safety*, 29 (11), 1011-1022.

Garland, A.M., Riskin, O.J., Brundage, S.I., Moritz, F., Spain, D.A., Purtill, M.A., Sherck, J.P. (2007). A county hospital surgical practice: a model for acute care surgery. *American journal of surgery*, 194(6), 758-763. discussion 763-4.

Garratt, A.M., Solheim, E., Danielsen, K. (2008). National and cross-national surveys of patient experiences: a structured review. Oslo. The Norwegian Knowledge Centre for the Health Services. Report from the Knowledge Centre no 07-2008. Available online at: www.oecd.org/dataoecd/43/58/39493930.pdf

Gillies, M.A.M., & Baldwin, F.J. (2001). Do patient information booklets increase perioperative anxiety? *European Journal of Anaesthesiology*, 18, 620-622.

Gilmartin J. (2007). Contemporary day surgery: patients' experiences of discharge and recovery. *Journal of Clinical Nursing*, 16, 1109-1117.

Gilmartin, J., & Wright, K. (2008). Day surgery: patients' felt abandoned during the preoperative wait. *Journal of Clinical Nursing*, 17, 2418-2425.

Gilmour, J.M. (2006). Patient safety, medical error and tort law: an international comparison: final report. Osgoode Hall Law School, York University.

Goodrich, J., & Cornwell, J. (2008). The King's Fund. Seeing the person in the patient. The Point of Care review paper. 1-76. Available online at: www.kingsfund.org.uk/publications

Gordon, J., Sheppard, L.A., Anaf, S. (2010). The patient experience in the emergency department: A systematic synthesis of qualitative research. *International Emergency Nursing*, 18(2), 80-88.

Gough IR. (2008). Sub-specialization in surgery and the continuing challenge of providing emergency surgery services. *The Medical journal of Australia*, 189(7), 358-359.

Grimes, F. (2003). The Measurement of Patient Satisfaction with Acute Services in Ireland Irish. Patient satisfaction literature review and scoping exercise. Dublin: ISQSH, HSNPF. Available online at: www.isqsh.ie/docs/default.asp?mnu=8&folder=Patient+Participation

Hameed, S.M., Brenneman, F.D., Ball, C.G., Pagliarello, J., Razek, T., Parry, N., Widder, S., Minor, S., Buczkowski, A., MacPherson, C., Johner, A., Jenkin, D., Wood, L., McLoughlin, K.,

- Anderson, I., Davey, D., Zabolotny, B., Saadia, R., Bracken, J., Nathens, A., Ahmed, N., Panton, O., & Warnock, G.L. (2010). General surgery 2.0: the emergence of acute care surgery in Canada. *Canadian Medical Association. Canadian journal of surgery*, 53(2), 79-83.
- Hamilton, S.M., Letourneau, S., Pekeles, E., Voaklander, D., Johnston, D.W. (1997). The impact of regionalization on a surgery program in the Canadian health care system. *Archives of surgery (Chicago, Ill.: 1960)*, 132(6), 605-9; discussion 609-11.
- Hammond, S., & Royal, C. (2001). *Lessons from the field: Applying appreciative inquiry* (Revised ed.) (Hammond, S., Royal, C., Eds.). Thin Book Publishing Co.
- Hammond, S.A. & Royal, C. (2001). *Lessons from the Field: Applying Appreciative Inquiry*. Revised Edition. Thin Book Publishing Co.
- Hammond, S.A. (1998). *The Thin Book of Appreciative Inquiry*. (2nd Edition). Plano, Texas: Thin Book Publishing Company.
- Hanson Smart, D. & Mann, M. (2003). Incorporating appreciative inquiry methods to evaluate a youth development program. *New Directions for Evaluation*, 2003, 63–74.
- Havens, D.S., Wood, S.O., Leeman, J. (2006). Improving nursing practice and patient care: building capacity with appreciative inquiry. *The Journal of Nursing Administration*, 36(10), 463-470.
- Henderson, A., Caplan, G., Daniel, A. (2004). Patient satisfaction: the Australian patient perspective. *Australian Health Review*, 27(1), 73-83.
- Hirunwat, P. (2011). Appreciative inquiry-based organization development intervention process on satisfaction and engagement of senior patients and sustainability of sukavet institution: A Case Study of Nursing Home. *The First International Conference on Interdisciplinary Research and Development*, 31 May-1 June 2011, Thailand. 78.1-78.6
- Holman, P., Paulson, A., Nichols, L. (1998). *Lessons from the field: Applying appreciative inquiry*. Chapter 5. Practical Press, Inc.
- Isaac, T., Zaslavsky, I., Cleary, P., & Landon, B. (2010). The relationship between patients' perception of care and measures of hospital quality and safety. *Health Services Research*, 45(4), 1024-1040.
- Jacobsgaard, M. (2003). Using appreciative inquiry to evaluate project activities of a nongovernmental organization supporting victims of trauma in Sri Lanka. *New Directions for Evaluation*, 2003: 53–62.
- Jones, K.R., Burney, R.E., & Christy, B. (2000). Patient expectations for surgery: are they being met? *Journal on Quality Improvement, Joint Commission on Accreditation of Healthcare Organizations*, 26(6), 349-360.

- Jurkovich, G.J. (2007). Acute care surgery: the trauma surgeon's perspective. *Surgery*, 141, 293-296.
- Kamming, D., Chung, F., Williams, D., McGrath, B.M., & Curti, B. (2004). Pain management in ambulatory surgery. *Journal of Peri Anesthesia Nursing*, 19(3), 174-182.
- Kaplan, L.J., Frankel, H.L., Hojman, H., Portereiko, J., Rabinovici, R. (2005). What price for general surgery? *Journal of Trauma*, 59(2), 391-4, discussion 394-5.
- Kholdebarin, R., Helewa, R.M., Hochman, D.J. (2011). Evaluation of a regional acute care surgery service by residents in general surgery. *Journal of Surgical Education*, 68(4), 290-293.
- Kholdebarin, R., Helewa, R.M., Hochman, D.J. (2011). Evaluation of a regional acute care surgery service by residents in general surgery. *Journal of surgical education*, 68(4), 290-293.
- Kim, P.K., Dabrowski, G.P., Reilly, P.M., Auerbach, S., Kauder, D.R., Schwab, C.W. (2004a). Redefining the future of trauma surgery as a comprehensive trauma and emergency general surgery service. *Journal of the American College of Surgeons*, 199(1), 96-101.
- Kim, S.S, Kaplowitz, S., & Johnston, M.V. (2004b). The effect of physician empathy on patient satisfaction and compliance. *Evaluation & the Health Professions*, 27(3), 237-251.
- Klein, E. R. (2005). Effective communication with patients. *Pennsylvania Nurse*, 60(4), 14-15.
- Kreindler, S.A., Beaudin, P., Raynard, M., Moffatt, M.E.K., Nason, R.W., Hochman, D., Yaffe, C.S. (2010). Outcomes of consolidating non-elective surgery: the "surgical hospitalist/acute-care surgery" model. A systematic review. Unpublished report, Winnipeg Regional Health Authority.
- Kreindler, S.A., Zhang, L., Metge, C.J., Nason, R.W., Moffatt, M.E.K., Wright, B., Rundnick, W. (2011). Outcomes of regionalizing acute-care surgery: report on quantitative findings. Unpublished report, Winnipeg Regional Health Authority.
- Lehane, C.W., Jootun, R.N., Bennett, M., Wong, S., & Truskett, P. (2010). Does an acute care surgical model improve the management and outcome of acute cholecystitis? *ANZ Journal of Surgery*, 80(6), 438-442.
- Letterstal, A., Eldh, A.C., Olofsson, P., & Fordberg, C. (2010). Patients' experience of open repair of abdominal aortic aneurysm- postoperative information, hospital care and recovery. *Journal of Clinical Nursing*, 19, 3112-3122.
- Levinson, W., Gorawara-Bhat, R., & Lamb, J. (2000). A study of patient clues and physician responses in primary care and surgical settings. *JAMA: the journal of the American Medical Association*, 284(8), 1021-1027.
- Liamputtong, P. (2009). *Qualitative Research Methods*. (3rd Edition). Oxford University Press.

- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. London: Sage.
- Maa J, Carter JT, Gosnell JE, Wachter R, Harris HW. (2007). The surgical hospitalist: a new model for emergency surgical care. *Journal of the American College of Surgeons*, 205(5), 704-711.
- McCabe, C. (2004). Nurse-patient communication: an exploration of patients' experiences. *Journal of Clinical Nursing*, 13, 41-49.
- Miner, G. (2002). Communication can mean the difference between life and death. *A Newsletter from the National Patient Safety Foundation*, 5, 2.
- Mitchell, M. (2001). Constructing information booklets for day-case patients. *Ambulatory Surgery*, 9(1), 37-45.
- Mordiffi, S.Z., Tan, S.P., Wong, M.K. (2003). Information provided to surgical patients versus information needed. *AORN Journal*, 77(3), 546-9, 552-8, 561-2.
- Morris-Donovan, B., Hopkins, G., Watts, I. (2008). Regaining trust after an adverse event: an education module on managing adverse events in general practice. *The Royal Australian College of General Practitioners*, South Melbourne, Victoria 3205, 5-96.
- Mottram, A. (2011). Like a trip to McDonald: A grounded theory of patient experiences of day surgery. *International Journal of Nursing Studies*, 48, 165-174.
- Murray, S., Crouch, R., Pope, C., Lattimer, V., Thompson, F., Deakin, C., & Ainsworth-Smith, M. (2011). 019 improving the quality of ambulance crew hand-over: a qualitative study of knowledge transfer in emergency care teams. *Emergency Medicine Journal*, 28(3), e1.
- Nairn, S., Whotton, E., Marshal, C., Roberts, M., & Swann, G. (2004). The patient experience in emergency departments: a review of the literature. *Accident and Emergency Nursing*, 12, 159-165.
- NHS Confederation. (2010) *Feeling better? Improving patient experience in hospital. The voice of NHS leadership*. Published by the NHS Confederation. London: NHS Confederation. Available online at: www.nhsconfed.org
- Odell, M. (2000). *An Appreciative Inquiry conversation guide: Creating a small forum in which leaders of the world religions can gather in mutual respect and dialogue (Winter ed.) (Vol.1)*. Global Social Innovations, Journal of the GEM Initiative.
- Pandhi, N. & Saultz, J.W. (2006). Patients' perceptions of interpersonal continuity of care. *Journal of the American Board of Family Medicine*, 19, 390-397.
- Parasyn, A.D., Truskett, P.G., Bennett, M., Lum, S., Barry, J., Haghghi, K., & Crowe P.J. (2009). Acute-care surgical service: a change in culture. *ANZ journal of surgery*, 79(1-2), 12-18.

- Pereira, A.G., & Pearson, S.D. (2003). Patient attitudes toward continuity of care. *Archives of internal medicine*, 163, 909–912.
- Poland, B. (2001). Transcription quality. In J. G. J. Holstein (Ed.), *Handbook of interview research: Context and method* (pp. 629-649). London: Sage Publications.
- Pryor, J.P., Reilly, P.M., Schwab, C.W., Kauder, D.R., Dabrowski, G.P., Gracias, V.H., et al. (2004). Integrating emergency general surgery with a trauma service: Impact on the care of injured patients. *Journal of Trauma*, 57(3), 467-473.
- Reed, J., & Turner, J. (2005). Appreciating change in cancer services – an evaluation of service development strategies. *Journal of Health Organization and Management*, 19(2), 163-176.
- Reed, J., Pearson, P., Douglas, B., Swinburne, S., & Wilding, H. (2002). Going home from hospital - An Appreciative Inquiry Study. *Health & Social Care in the Community*, 10, 36-45.
- Reid, R.J., Haggerty, J.L., McKendry, R. (2002). Defusing the confusion: concepts and measures of continuity of healthcare. Final Report, the Canadian Health Services Research Foundation. Available online at: www.chsrf.ca
- Rhodes, K.V., Vieth, T., He, T., Miller, A., Howes, D.S., Bailey, O., Frankel, R., Levinson, W. (2004). Resuscitating the physician–patient relationship: emergency department communication in an academic medical centre. *Annals of Emergency Medicine*, 44 (3), 262–267.
- Rhodes, L., Miles, G., Pearson, A. (2006). Patient subjective experience and satisfaction during the preoperative period in day surgery: a systematic review. *International Journal of Nursing Practice*, 12 (4), 178-192.
- Rocchi, A., Chung, F., Forte, L. (2002). Canadian survey of postsurgical pain and pain medication experiences. *Canadian Journal of Anesthesia*, 49(10), 1053-1056.
- Rodin, G., Mackay, J.A., Zimmermann, C., Mayer, C., Howell, D., Katz, M., Sussman, J., & Brouwer, M. (2009). Clinician–patient communication: a systematic review. *Support Care Cancer*, 17, 627–644.
- Roettger, R.H., Taylor, S.M., Youkey, J.R., Blackhurst, D.W. (2005). The general surgery model: a more appealing and sustainable alternative for the care of trauma patients. *The American surgeon*, 71(8), 633-8, discussion 638-9.
- Royal College of Physicians. (2002). Isolated acute medical services. Current organisation and proposals for the future. Report of a working party of the Royal College of Physicians. London: RCP.
- Russell, T.R. (2007). The surgical workforce: averting a patient access crisis. *The Surgical clinics of North America*, 87(4), 797-809.

- Salsberg, E., & Grover, A. (2006). Physician workforce shortages: implications and issues for academic health centers and policymakers. *Academic medicine*, 81:782–787.
- Sanchez, M., & Sariago, J. (2009). The general surgeon shortage: causes, consequences, and solutions. *Southern Medical Journal*, 102(3), 291-294.
- Sanmartin, C., Pierre, F., Tremblay, S. (2006). Waiting for Care in Canada: Findings from the Health Services Access Survey. *Healthcare Policy*, 2(2), 43-51.
- Sheldon, G.F. (2007). Workforce issues in general surgery. *The American Surgeon*, 73(2), 100-108.
- Sherwood, G.D., McNeill, J.A., Starck, P.L., & Disnard, G. (2003). Changing acute pain management outcomes in surgical patients. *AORN Journal*, 77(2), 374, 377-80, 384-90 passim.
- Sizmur, S. & Redding, D. (2009). Core domains for measuring inpatients' experience of care. Picker Institute Europe, King's Mead House, 1-20. Available online at: www.pickereurope.org
- Sorelli, P.G., El-Masry, N.S., Dawson, P.M., Theodorou, N.A. (2008). The dedicated emergency surgeon: towards consultant-based acute surgical admissions. *Annals of the Royal College of Surgeons of England*, 90(2), 104-108.
- Soremekun, O.A., Takayesu, J.K., Bohan, S.J. (2011). Framework for Analyzing Wait Times and Other Factors that Impact Patient Satisfaction in the Emergency Department. *The Journal of Emergency Medicine*, Article in press, 1-7.
- Stanley, M.D., Davenport, D.L., Procter, L.D., Perry, J.E., Kearney, P.A., & Bernard, A.C. (2011). An acute care surgery rotation contributes significant general surgical operative volume to residency training compared with other rotations. *The Journal of Trauma*, 70(3), 590-594.
- Street, R.L. Jr., Gordon, H.S., Ward, M.M., Krupat, E., & Kravitz, R.L. (2005). Patient participation in medical consultations: why some patients are more involved than others. *Medical Care*, 43(10), 960-969.
- Sutcliffe, K.M., Lewton, E., Rosenthal, M.M. (2004). Communication failures: an insidious contributor to medical mishaps. *Academic medicine: journal of the Association of American Medical Colleges*, 79(2), 186-194.
- Taylor, C., & Benger, J.R. (2004). Patient satisfaction in emergency medicine. *Journal of Emergency Medicine*, 21, 528-532.
- The Beryl Institute. (2010). Business news; patient experience confirmed as priority for hospitals through survey by the beryl institute. *Investment Weekly News*, (19458177), 1265. Retrieved from www.search.proquest.com/docview/762230921?account=14569

The Committee on Acute Care Surgery American Association for the Surgery of Trauma. (2007). The acute care surgery curriculum. *Journal of Trauma*, 62 (3), 553-556.

The Joint Commission on the Accreditation of Health Care Organizations. (2009). *The Joint Commission Guide to Improving Staff Communication (2nd Edition)*. Joint Commission Resources, Inc.

The Picker Institute. Principles of patient-centered care. Retrieved on May 7, 2011 from www.pickerinstitute.org

Thompson, D.A., Yamold, P.R., Williams, D.R., Adams, S.L. (1996). Effects of actual waiting time, perceived waiting time, information delivery, and expressive quality on patient satisfaction in the emergency department. *Annals of Emergency Medicine*, 28(6), 657-665.

Tisherman, S.A., Ivy, M.E., Frangos, S.G., & Kirton, O.C. (2011). Acute care surgery survey: opinions of surgeons about a new training paradigm. *Archives of Surgery*, 46(1), 101-106.

Tzavaras Catsambas, T., & Webb, L.D. (2003). Using appreciative inquiry to guide an evaluation of the International Women's Media Foundation Africa program. *New Directions for Evaluation*, 41-51.

Vrangbaek, K., Østergren, K., Birk, H.O., Winblad, U. (2007). Patient reactions to hospital choice in Norway, Denmark, and Sweden. *Health Economic, Policy, and Law*, 2(2), 125-52.

Wallace, P.G.M. & Ridley, S.A. (1999). Transport of critically ill patients. *British Medical Journal*, 319 (7206), 368-371.

Watkins, J.M., & Cooperrider, D.L. (2000). Appreciative inquiry: A transformative paradigm. *Journal of the Organization Development Network*, 32, 6-12.

Williams, B., Coyle, J., Healy, D. (1998). The meaning of patient satisfaction: an explanation of high reported levels. *Social Science and Medicine*, 47(9), 1351-1359.

Williams, C.A., & Gossett, M.T. (2001). Nursing communication: advocacy for the patients or physician? *Clinical Nursing Research*, 10(3), 332-340.

Williamson, P.R., & Suchman, A.L. (2004). Changing the culture of a medical school using appreciative inquiry and an emergent process. *AI Practitioner*. 2004 (May): 22-25.

Winnipeg Regional Health Authority. Retrieved on July 16, 2011 from www.wrha.mb.ca

Wood, L., Buczkowski, A., Panton, O.M., Sidhu, R.S., Hameed, S.M. (2010). Effects of implementation of an urgent surgical care service on subspecialty general surgery training. *Canadian journal of surgery*, 53(2), 119-125.

Wood, S. (2004). Creating a positive future for nursing using appreciative inquiry. *AI Practitioner*. Available online at: www.appreciativeinquiry.case.edu

World Health Organization. (2002). Quality of care: patient safety. Fifty-fifth World Health Assembly. Provisional agenda item 13.9. Available online at: www.who.int/gh/archive/pdf_files/WHA55

Zakariasen, K.L., Zakariasen, K.A., Lodding, D. (2002). The Practice of Your Future: Creating a Vision. *The Journal of the American Dental Association*, (133), 213-218.

Zhan, C., & Miller, M.R. (2003). Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization. *Journal of the American Medical Association*, 290 (14), 1868-74.

APPENDIX A

SEMI-STRUCTURED INTERVIEW GUIDE

Thank you for agreeing to be interviewed. This is a Master's Thesis project to help Winnipeg Regional Health Authority (WRHA) plan for the future in order to improve acute care surgical services. I am interested in finding out what is working well, what could be working better, and what changes would be helpful to improve acute care surgery programs.

I understand that you had an acute/emergency surgery recently. Your stories and experiences regarding the acute care surgery will help us to learn and improve surgery services. I'm going to ask you some questions to encourage you to tell about your experience. Your stories will not be identifiable to you individually and will be kept confidential.

Have you any questions before we begin?

Open-ended Questions:

- 1- Overall, how would you describe your experiences regarding your acute care surgery and the surgical care provided?
 - a. Can you tell me more about that?

- 2- What do you value *the most* about the acute care surgical services that you received? (What do you like the most? What is the most important?)

For the next 6 questions, I am going to ask you to tell stories about your experience.

- 3- Could you please tell me about your acute care surgery?
 - a. What happened at the beginning?
 - b. How did you come to the Emergency Room (ER)? Which ER?
 - c. What happened at the ER?
 - d. How and when did you find out you needed surgery?
 - e. Who was involved?
 - f. What were your feelings?
 - g. What happened in the end? How did it turn out?

- 4- Thinking back on your experiences, I would like you to think of an experience regarding your acute care surgery that you felt went really well.
 - a. Please tell me the story of that experience.
 - b. Who was involved?
 - c. What were your feelings?
 - d. What happened in the end? How did it turn out?
 - e. What made this experience meaningful for you?

- 5- There may also be aspects of the care that you received that you were less happy about. I would like you to think of an experience that could have been improved.

- a. Please tell me the story of that experience.
 - b. Who was involved?
 - c. What were your feelings?
 - d. What happened in the end? How did it turn out?
 - e. What made this experience unhappy and less helpful for you?
- 6- Thinking back about your acute surgery, did you have any transfer/s between hospitals prior to the surgery?
- a. Please tell me the story of that.
 - b. How did you find out about it?
 - c. Who was involved?
 - d. What were your feelings?
 - e. What happened in the end? How did it turn out?
- 7- Thinking back about your acute surgery, information was communicated to you and your family member during the process of the acute care surgery. I would like you to think of an experience that you felt involved the best communication.
- a. Please tell me the story of that.
 - b. Who was involved?
 - c. What were your feelings?
 - d. What was the outcome of the communication?
 - e. What made this experience helpful for you?
- 8- Think back about your experience. There may be some aspects of the communication that you were less happy about. I would like you to think of an experience that could have been improved.
- a. Please tell me the story of that experience.
 - b. Who was involved?
 - c. What were your feelings?
 - d. What happened in the end? What was the outcome of the situation?
 - e. What made this experience less helpful for you?

So, you have told me quite a few stories about your experiences of your acute care surgery.

- 9- Overall, how have the acute care surgical services that you received affected your health? (positive/negative?)
- 10- From your point of view, how could the WRHA improve the acute care surgery services and make the surgical services a better experience?
- 11- I have no more questions; what about you? Is there anything else you would like to ask or add?

Thank you for your time and participation.

APPENDIX B

RECRUITMENT INSTRUCTIONS AND SCRIPT FOR SURGICAL NURSING STAFF

Researcher: Elham Saded, (204) - 926-7087.

We are interested in interviewing individuals who receive acute care surgery at your site. Potential participants must meet the following criteria:

- 18 years of age or older
- Diagnosed with *Acute Appendicitis, Acute Cholecystitis, or Acute Small Bowel Obstruction*
- Received acute care surgery from one of the ACS sites including: Health Science Centre, St. Boniface General Hospital, and Grace General Hospital
- Able to read and speak English
- Stable mental and physical health status
- Live in the city of Winnipeg

We appreciate your help in informing the eligible participants about the research study and asking their permission to be contacted by the researcher, while they are still in hospital recovering.

1. Please identify patients who meet the above selection criteria. If a patient meets the criteria, please talk to the patient and inform him/her about the study, and request their permission to pass their name to the researcher (Elham Sadeh).
2. Please explain the study to the participants according to the attached script. Note that we are asking permission for the researcher to contact and meet the patients. This is not a commitment to participate in the study.
3. Please answer any of their questions to the best of your ability.
4. Please ask the patients if they would be willing to allow you to provide their name to the researcher. Let them know that the researcher will talk to them at the hospital and provide more detailed information about the research study.
5. Add the patient's name to the master list and whether the patient has agreed/not agreed to be contacted by the researcher to avoid approaches by multiple surgical staff. The surgical staff will have access to the master list.
6. The researcher will visit your unit regularly and ask if any patient is interested in the research study and willing to meet the researcher.

Thank you for your help.

Script for surgical staff

I've been asked to inform you about a research study regarding the circumstances and experience of your surgical care and invite you to participate in an interview after discharge. Is it okay to talk about it now? It will only take a few moments.

I am not allowed to pass your name to the researcher without your permission, so I've been asked to tell you a little about the research project and then ask you to consider allowing me to provide your name to the researcher. Your care here will not be affected by whether or not you agree to meet with a researcher. The researcher will meet you and explain the purpose of study and the process of interview in more detail.

The research study is called "Consolidation of Acute Care Surgical Services: Learning from Patient Experiences". The researcher is interested in finding out what is working well and what could be working better in acute care surgical services. The result of the study will be used to improve acute care surgical services. The researcher does not work for our hospital and wants to hear your stories and experiences of your acute care surgery.

Right now, the researcher is only asking for permission to meet you. The researcher may not meet everyone who agreed to be contacted. The researcher will explain the study and invite you to participate in an individual interview. That is when you would decide if you will take part. For now, we are just asking if the researcher can meet you and talk about the research study.

Your decision to meet the researcher is completely voluntary. By agreeing to meet the researcher, you are not agreeing to participate in the interview but only that your name given to the researcher.

Do you have any questions? You are free to discuss this with your friends, family, and others before you make your decision.

Would you like me to pass your name to the researcher?

Thank you for your time and consideration.

APPENDIX C

RESEARCH STUDY POSTER

An Important *Research Study* titled as:

“Consolidation of Acute Care Surgical Services: Learning from Patient Experiences”

Why are we doing this research?

In order to improve acute care surgical services at the Winnipeg Regional Health Authority (WRHA), we are interested in finding out what is working well, what could be working better, and what changes would be helpful in the acute care surgical services from the patient’s point of view.

The purpose of this study is: to explore how the adult recipients of acute care surgery at the Winnipeg Regional Health Authority (WRHA) perceive the care provided to them.

We are looking for potential participants who:

- ❖ Are 18 years of age or older
- ❖ Diagnosed with: ♦ *Acute Appendicitis*, ♦ *Acute Cholecystitis*, ♦ *Acute Small Bowel Obstruction*
- ❖ Received acute care surgery from one of the ACS sites including: **Health Sciences Centre, St. Boniface General Hospital, and Grace General Hospital**
- ❖ Able to read and speak English
- ❖ Stable mental and physical health status
- ❖ Live in the city of Winnipeg

What is involved in this research?

- ❖ We are looking for participants who are willing to be interviewed and share their experiences of acute care surgery.
- ❖ The participation in the interview is voluntary.
- ❖ The interview usually takes about one hour.
- ❖ The interview will be scheduled for a time and place convenient to the participants.
- ❖ A written, informed consent will be obtained from each participant.

Please feel free to contact the researcher, Elham Sadeh, at (204) - 926-7087. Thank you!

APPENDIX D

INTERVIEW PARTICIPANT INFORMATION AND CONSENT FORM

Title: “Consolidation of Acute Care Surgical Services: Learning from Patient Experiences”.

Principal Investigator: *Elham Sadeh*

*Medical Services Bldg.
S113 - 750 Bannatyne Avenue
Winnipeg, Manitoba, Canada R3E 0W3
(204)- 926-7087*

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions with the study staff. You may also like to talk about this with your family or friends.

Purpose of Evaluation

The purpose of this qualitative study is to explore how the recipients of acute care surgery at the Winnipeg Regional Health Authority (WRHA) perceive the care provided to them and, to find out what is working well, what could be working better, and what changes would be helpful in acute care surgery programs from the point of view of the patient. This will help the WRHA to improve the acute care surgical services that they provide.

Evaluation procedures

You are being asked to participate in an interview. Your participation in the interview is voluntary. The interview usually takes about one hour. The interviewer will ask you questions about your experiences of your acute care surgery. This interview will be scheduled for a time and place convenient to you.

Fifteen to twenty people are expected to participate in interviews. The interview will be audio-taped to ensure that the interviewer’s full attention can be directed to the participants’ stories, and we can capture comments in a transcript for analysis. The audio recording made during the interviews will be destroyed after transcribing and verifying themes.

You will also be invited to participate in a follow-up focus group to discuss what was learned from the interviews. You are free to decide whether you would like to take part in this group.

You may stop participating at any time. However, if you decide to stop participating in the study, we encourage you to talk to the study staff first.

Risks and Benefits

We do not think there are any risks to participating in this interview and there may not be any benefit to you from participating in this study. We hope the information learned from this study will benefit other people who require acute care surgical services in the future.

Costs and payments

There is no cost for your participation, and you will not be paid.

Confidentiality

The results of this study may be published or presented publicly, but your name and other identifying information will not be used.

We will do our best to keep your personal information confidential, but absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law. The University of Manitoba Health Research Ethics Board may review records related to the evaluation for quality assurance purposes.

All notes, tape records, and consent forms will be kept locked in the researcher's office. No personal information such as your name or telephone number will leave the researcher's office.

Voluntary Participation/Withdrawal from the Evaluation

Your decision to take part in this study is voluntary. You may refuse to participate, you may withdraw from the study at any time, or you may refuse to answer any questions asked.

Your decision to participate or not to participate in the study and anything you say during the interviews will not affect the services you receive from the Winnipeg Regional Health Authority.

Questions

You are free to ask any questions that you may have. If questions come up during or after the study, call the principal investigator: Elham Sadeh at (204) 926-7087.

For questions about your rights as a research participant, you may contact the University of Manitoba Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research study with Elham Sadeh and my questions have been answered. I understand that my participation is voluntary, and I freely agree to participate in this study. I understand that information about my personal identity will be kept confidential.

By signing this consent form, I have not waived my legal rights as a research participant.

I agree to participate in an individual interview for this research study.

_____ Yes _____ No

I agree that the interview can be audio-recorded.

_____ Yes _____ No

I agree that notes may be taken of my responses.

_____ Yes _____ No

I agree to be contacted for a follow-up focus group in relation to this study.

_____ Yes _____ No

Participant signature: _____ Date: _____

Participant printed name: _____

If you would like to review the notes from your interview, please print your address or email address below:

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed Name: _____ Date _____

Signature: _____

Role in the study: _____

INTERVIEW PARTICIPANT INFORMATION AND CONSENT FORM

FOCUS GROUP

Title: “Consolidation of Acute Care Surgical Services: Learning from Patient Experiences”.

Principal Investigator: *Elham Sadeh*

Medical Services Bldg.

S113 - 750 Bannatyne Avenue

Winnipeg, Manitoba, Canada R3E 0W3

(204)- 926-7087

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions with the study staff. You may also like to talk about this with your family or friends.

Purpose of Evaluation

The purpose of this qualitative study is to explore how the recipients of acute care surgery at the Winnipeg Regional Health Authority (WRHA) perceive the care provided to them and, to find out what is working well, what could be working better, and what changes would be helpful in acute care surgery programs from the point of view of the patient. This will help the WRHA to improve the acute care surgical services that they provide.

Evaluation procedures

You have already participated in an interview for this research study. You are now being asked to participate in a follow-up focus group. You will meet with a group of 6-10 other study participants. The summarized results from the interviews will be shared with the group, and participants will be asked questions about how the results fit with their experiences. The focus group approximately takes about one and half hours. The focus group will be audio-taped. The audio recording made during the interviews will be destroyed after transcribing and verifying themes.

If you would like, you may ask to see a summary of the notes from the focus group.

Risks and Benefits

We do not think any risks or discomforts as a result of participating in the focus group. Even though we will emphasize to all participants that comments made during the focus group should be kept confidential, it is possible that participants may repeat comments outside of the group at some time in the future. Therefore, we encourage you to be as honest and open as you can, but remain aware of our limits in protecting confidentiality.

Costs and payments

There is no cost for your participation, and you will not be paid. We will cover parking and travel expenses.

Confidentiality

The results of this study may be published or presented publicly, but your name and other identifying information will not be used.

We will do our best to keep your personal information confidential. Focus group participants will be reminded that everything they hear in the focus group is not to be repeated outside of the focus group, but absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law. The University of Manitoba Health Research Ethics Board may review records related to the evaluation for quality assurance purposes.

All notes, tape records, and consent forms will be kept locked in the researcher's office. Study data including notes, transcripts, and consent forms from focus group interviews will be kept for two years following the completion of the thesis. No personal information such as your name or telephone number will leave the researcher's office.

Voluntary Participation/Withdrawal from the Evaluation

Your decision to take part in this study is voluntary. You may refuse to participate, you may withdraw from the study at any time, or you may refuse to answer any questions asked.

Your decision to participate or not to participate in the study and anything you say during the interviews will not affect the services you receive from the Winnipeg Regional Health Authority.

Questions

You are free to ask any questions that you may have. If questions come up during or after the study, call the principal investigator: Elham Sadeh at (204) 926-7087.

For questions about your rights as a research participant, you may contact the University of Manitoba Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research study with Elham Sadeh and my questions have been answered. I understand that my participation is voluntary, and I freely agree to participate in this study. I understand that information about my personal identity will be kept confidential, but that confidentiality cannot be guaranteed.

By signing this consent form, I have not waived my legal rights as a research participant.

I agree to participate in a focus group.

_____ Yes _____ No

I agree that the focus group can be audio-recorded.

_____ Yes _____ No

I agree that notes may be taken of my responses.

_____ Yes _____ No

Participant signature: _____ Date: _____

Participant printed name: _____

If you would you like to review the summarized notes from your focus group, please print your address or email address below:

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed Name: _____ Date _____

Signature: _____

Role in the study: _____

APPENDIX E

DEMOGRAPHIC INFORMATION SHEET

Date:

Time:

Place:

Participant code:

1. Gender:
Female Male

2. Type of acute surgery:
___ Acute Appendicitis
___ Acute Cholecystitis
___ Acute Small Bowel Obstruction

3. Acute Care Surgery Site:
___ Health Sciences Centre
___ St. Boniface General Hospital
___ Grace General Hospital

4. Age:
___ ___

5. Level of Education:
___ Less than a high school Diploma
___ High School Diploma
___ Some College
___ Bachelor Degree
___ Masters Degree
___ Doctoral Degree
___ Professional Degree
___ Other