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Patient perspective on care transitions after colorectal surgery



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ABSTRACT

Background: The surgical care pathway is characterized by multiple transitions, from pre-operative assessment to inpatient stay, discharge from hospital, and follow-up care. Breakdowns in one phase can affect subsequent phases, which in turn can cause delays, cancellations, and complications. Efforts to improve care transitions focused primarily on post-discharge care coordination and inpatient education for medically complex patients have not demonstrated consistent effects. This study aimed to understand the expectations and perceptions of postoperative inpatients regarding transition from hospital to home in an effort to reduce patient burden.

Materials and methods: Patients who underwent a colorectal resection at a large academic medical center and were discharged home were eligible to participate in the study. Patients were recruited during their postoperative hospital stays and interviewed over the phone within a week after discharge about their perceptions of care, values, and attitudes. Overall, we recruited 16 patients with benign ($n = 8$) and malignant ($n = 8$) indications. Recruitment continued until theme saturation.

Results: Factors that shaped patients' understanding of postsurgical recovery and that motivated them to seek provider attention post-discharge fell into three major groups: patient expectations versus reality, availability and role of informal caregivers in the postoperative recovery process, and communication as a key to patient confidence and trust.

Conclusions: For patients and caregivers, postoperative planning starts long before surgery and hospital admission. Providers should consider these dynamics in designing interventions to improve care transitions, patient satisfaction, and long-term outcomes. This study was limited to colorectal surgical patients treated in a single institution and may be not generalizable to other surgical procedures, non-academic settings or different regions.

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Introduction

The number of surgical procedures performed annually in the United States continues to grow and now exceeds 14 million.¹ The surgical care pathway is characterized by multiple transitions, from preoperative assessment to inpatient stay, discharge from hospital, and follow-up care. Providing optimal care across all the phases of the surgical pathway has become increasingly challenging, due to the complexity of procedures, increasing time pressures on staff, and demands for a patient-centered approach.² The planning and execution of postsurgical discharges for cancer patients is of particular interest because post-discharge complications may lead to hospital readmissions, delays in adjuvant treatment, poor cancer outcomes,^{3–7} and provider penalties.^{8–12} Hospital discharge for frail older patients is further complicated because of the increased need to coordinate rehabilitation, home care services, and transportation and to be inclusive of informal caregivers.

Surgical admissions are different from most medical admissions in that a large proportion of surgical procedures are elective rather than emergent. Despite the opportunity to plan and prepare before surgery, efforts to reduce complications and minimize readmissions have largely focused on post-discharge care coordination plus some in-hospital training and education opportunities for high-risk patients, with mixed results.^{13,14} The most effective interventions are complex multidisciplinary programs that emphasize the patient's ability for self-care and communication among all members of the care team.^{13,14} Previous studies have demonstrated, however, that surgical patients often have unrealistic or inaccurate expectations about the effects of their operations and their postsurgical function and recovery process.¹⁵ This misalignment may negatively affect patients' ability to prepare for and cope with the postsurgical recovery process.^{15–19} Finally, the time in the hospital immediately after a surgical procedure is not optimal for learning new self-care skills.^{5,20}

Qualitative research methods are particularly suited to gaining a deeper understanding of the patient perspective on factors affecting care transitions and to identifying appropriate metrics and outcomes for subsequent quantitative studies. In-depth interviews, although not intended to generate statistically representative results, are the main approach to examine how patients form expectations about surgery and recovery and how they cope with stress, uncertainty, and complications. The aim of this qualitative study was to examine patient perspectives on their postsurgical experience, something that has not been well understood in the past. Ultimately, our goal was to identify modifiable factors and strategies as targets for quality improvement and to redesign the processes of care to improve patients' experiences after major abdominal surgery.

Materials and methods

To develop the study protocol and guide the analysis, we followed the commonly used qualitative study checklist and the Consolidated Criteria for Reporting Qualitative Research

developed by Tong *et al.*²¹ We developed an interview guide (Appendix Table 1) with the following domains of investigation informed by prior studies^{3–9,13–20,22–29}: (1) readiness for hospital discharge; (2) physical functioning; (3) emotional functioning; (4) social functioning; and (5) informal caregivers. We also included open-ended questions regarding patient perceptions on each of these general domains as well as on their disease and recovery and their relative importance.

Sampling framework

Using stratified purposive sampling, we recruited patients aged 18 y or older, undergoing colon or rectal resection (either benign or malignant indication) at a large academic medical center according to standardized care protocols between December 2013 and March 2014 (Table 1).^{22–24} The recruitment strategy aimed to identify a diverse group of patients to include a wide variety of patient experiences. The patients' advanced practice providers introduced the study to the patients in the hospital setting, and written informed consent was obtained before discharge. Institutional review board approval for the study was obtained before subject recruitment and any data collection (Research Subjects Review Board approval 000049044). Subjects who lacked capacity to consent and those who needed a stay in a skilled nursing facility were excluded. With the rolling study design, recruitment and patient interviews continued until theme saturation was reached. "Saturation" is an approach used for purposive samples, the most commonly used form of nonprobabilistic sampling for qualitative studies. This approach relies on the concept of "saturation," the point at which no new information or themes are observed in the data as more subjects are recruited and interviewed. In our study, theme saturation was determined by the study team through an ongoing preliminary analysis of recorded patient interviews.

Once a patient agreed to participate in the study, the study coordinator abstracted sociodemographic (age, gender, race, availability of a caregiver), clinical (preoperative diagnosis and comorbidities, functional status) and hospital data (type of procedure, attending surgeon, and presence or absence of a stoma^{25–30}) from the electronic medical record.

Table 1 – Sampling framework groups.

Primary criteria	
Male	Female
Age ≤ 65 y	Age > 65 y
Stoma	No stoma
Potential secondary criteria	
Open surgery	Laparoscopic surgery
Malignant pathology	Benign pathology
Caregiver at home	No caregiver at home
Postoperative complication	No postoperative complications
Short length of stay	Prolonged length of stay
Unplanned 30-d readmission	No 30-d readmission

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