

Perceived learning needs of patients with abdominal aortic aneurysm



Olga Nilsson, RN, BSc, Rebecka Hultgren, MD, PhD, and Anna Letterstål, RN, PhD

Background: Patients undergoing surgical treatment of abdominal aortic aneurysm (AAA) should receive adequate information about the disease, treatment options, and self-care. Patients' learning needs should be acknowledged. The aim was to describe the perceived learning needs in patients with AAA. A secondary aim was to explore their experience of methods for patient education.

Methods: Three focus group interviews were conducted with 14 patients treated with open or endovascular repair of AAA. The interviews embraced initial diagnosis, surgical treatment, and follow-up from a learning perspective and were analyzed using qualitative content analysis.

Results: Three categories and 10 subcategories emerged. The health care staff failed to meet the participants' individual learning needs. Participants relied on other pathways to obtain knowledge, such as the internet or anecdotal information from friends and family. Learning needs pertained to risks and complications with surgery, self-care, and rupture risk. The participants were reluctant to ask questions due to a stressful environment. They requested accessible written information, along with a professional contact person for coordination and support during the care pathway.

Conclusions: Patients with AAA describe unmet learning needs in regard to risks and complications with the disease and surgical treatment but also disease management and lifestyle factors. Education material should be consistent, individualized and easily accessible for patients and next of kin. Additional psychosocial support is warranted. Adjusting information to patients' needs may improve patient satisfaction. (J Vasc Nurs 2017;35:4-11)

INTRODUCTION

Abdominal aortic aneurysm (AAA) is an asymptomatic and potentially lethal condition.¹ The definition of an AAA is a widening of the abdominal aorta exceeding 30 mm.² In population-based screening programs, AAA is detected in

1.5%-4% of 65-year-old men.^{3,4} As the size of the aneurysm increases, so does the risk of bursting, so called "rupture" which causes a massive intra-abdominal hemorrhage.⁴ Aneurysm rupture is life threatening, and without surgical treatment, the condition is fatal. Elective AAA repair is performed when the AAA diameter exceeds 55 mm, and two techniques are used: endovascular aortic repair (EVAR) or open repair (OR). During OR, the patient is treated with open abdominal surgery, and the aneurysmatic part of the aorta is replaced with a synthetic graft. EVAR is a minimally invasive procedure, using endovascular technique to insert a stent graft to exclude the aneurysm. The perioperative risk and postoperative complication rate differ between the two techniques.^{5,6} Patients who undergo EVAR have an average length of hospital stay of 3 days, compared with 7 days for OR patients.⁷ Although randomized trials have shown that EVAR offers a perioperative survival and morbidity benefit over OR for patients undergoing elective surgery, this advantage does not persist over time.^{8,9} After two years, mortality rates are comparable for EVAR and OR.¹⁰ However, EVAR patients require life-long follow-up due to the higher risk of endoleaks and subsequent aneurysm rupture compared to OR.¹⁰ The recent introduction of regional screening programs has, however, increased the number of AAA patients with small diameters under surveillance at vascular units.¹¹

There are somewhat contradictory findings on the effect of AAA diagnosis and treatment on estimated health-related quality of life (HRQoL).^{1,12} A systematic review was unable to conclude any relative benefits of the different treatments.¹² Some studies report short-term benefits of EVAR on HRQoL,^{13,14} while a randomized controlled trial reported no explicit benefit of either treatment modality on HRQoL.¹⁵ A recent study with a

From the Department of Vascular Surgery, Karolinska University Hospital, Stockholm, Sweden; Department of Molecular Medicine and Surgery, Karolinska Institutet, Stockholm, Sweden; Programme Office, Karolinska University Hospital, Stockholm, Sweden; Department of Medicine, Karolinska Institutet, Stockholm, Sweden.

Corresponding author: Olga Nilsson, RN, BSc, Department of Vascular Surgery A2:01, Karolinska Institutet, Karolinska University Hospital, SE-171 76 Stockholm, Sweden (E-mail: olga.nilsson@karolinska.se).

Funding: The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was supported by the Swedish Heart-Lung Foundation grant number: 20140722, the Magnus Bergvall Foundation, and by the regional Medical Training and Research Agreement (ALF) between Stockholm County Council and Karolinska Institutet.

Conflict of interest: The authors declare that there is no conflict of interest.

1062-0303/\$36.00

Copyright ©2016 by the Society for Vascular Nursing, Inc.

<http://dx.doi.org/10.1016/j.jvn.2016.08.003>

TABLE 1

PARTICIPANT CHARACTERISTICS

Variable	Interview I (n = 4)	Interview II (n = 3)	Interview III (n = 7)
	n (%)	n (%)	n (%)
Sex			
Male	3 (75)	3 (100)	6 (86)
Female	1 (25)	0	1 (14)
Age, mean (range)	71 (66–75)	76 (75–77)	77 (66–85)
Marital status			
Married	2 (50)	2 (67)	4 (57)
Widowed	0	1 (33)	3 (43)
Living alone	2 (50)	0	0
Employment status			
Working	1 (25)	0	1 (14)
Unemployed	0	0	0
Retired	3 (75)	3 (100)	6 (86)
Months since surgery, mean	7.25 (SD = 2.2)	4 (SD = 1.0)	19 (SD = 3.0)
Surgical technique			
Open repair	4 (100)	0	1 (14)*
Endovascular aortic repair	0	3 (100)	6 (86)
Comorbidity			
Cancer	1 (25)	1 (33)	0
Stroke	1 (25)	0	0
COPD	0	2 (67)	2 (29)
Renal insufficiency	0	1 (33)	1 (14)
Diabetes	1 (25)	0	1 (14)
Hypertension	2 (50)	3 (100)	4 (57)
CVD	2 (50)	3 (100)	4 (57)

COPD = chronic obstructive pulmonary disease; CVD = cardiovascular disease.

*One participant had been converted from EVAR to OR.

follow-up of 5 years after surgical treatment showed that EVAR has short-term HRQoL benefits over OR, but OR patients report higher HRQoL 5 years after surgery.¹⁶

Health care staff is required by national jurisdiction to provide patients with sufficient information to enable them to take active part in medical decision-making.¹ Patient participation is a concept, which comprises comprehension, mutual communication, having and applying knowledge, and being confident.¹⁷ Patient participation has been identified as a predicting factor for preventing postoperative complications in cardiac surgery and improving compliance with primary care recommendations.^{18,19} Social, cultural, and cognitive factors all influence the communication between patient and caregiver, and a deeper understanding for patients' perception of communication during the care pathway is essential for understanding their needs.²⁰ Taking these needs into account during the development of new education strategies

is crucial. The primary aim was to describe the perceived learning needs of patients with AAA. A secondary aim was to explore their experience of methods for patient education.

METHODS

Participants

All patients who had undergone surgical treatment with OR or EVAR at a University Hospital in Sweden more than three months before the study, who had survived and had attended their one-month follow-up visit at the vascular outpatient clinic were considered for inclusion. Patients were identified through medical records, contacted via telephone and invited to attend a focus group interview (FGI). Thirty-four patients were approached, of which 14 chose to participate. An inclusion criterion was the ability to understand and speak Swedish. Individuals with diagnosed cognitive

Download English Version:

<https://daneshyari.com/en/article/5570843>

Download Persian Version:

<https://daneshyari.com/article/5570843>

[Daneshyari.com](https://daneshyari.com)