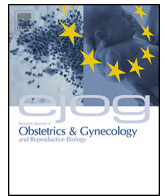




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# Factors that determine patient satisfaction after surgical treatment of ectopic pregnancy: improving the patient journey!

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### ABSTRACT

**Objectives:** The aim of our study is to identify factors that influence the woman's perception of satisfaction during the process of treatment for this potentially life threatening condition. To evaluate the patient characteristics and factors surrounding the diagnosis and subsequent management of women with ectopic pregnancy and the influence of these on the overall satisfaction rates after discharge from hospital in order to improve quality of care.

**Study design:** This is a prospective cohort study undertaken over a period of 4 years (January 2009–December 2012) in a busy early pregnancy unit, in a London university hospital, catering to a multi-ethnic diverse population. Six weeks after surgery a self-administered satisfaction questionnaire was filled in either after a clinician face to face or telephone interview for women who had undergone operative laparoscopy for the treatment for ectopic pregnancy. The data was analysed using SPSS version 14.0.

**Results:** A total of 324 women underwent operative laparoscopy for the treatment of ectopic pregnancy during the study period. Of this cohort 299 (92.3%) were included in the study, as 25 women (8.4%) were lost to follow-up. 247 (82.6%) were followed up in the clinic and 52 (17.4%) by telephone interview. In 69.5% of the cases the diagnosis was made by a single ultrasound scan, and 69% were discharged within 24 h of surgery. The amount of haemoperitoneum and subsequent need for blood transfusion had a significant influence on the overall satisfaction rates (blood loss <200 ml – 94% satisfied, 200–800 ml – 81% and >800 ml – 72%,  $p = 0.001$ ). While age, parity, ethnicity, desire for future pregnancy did not affect the satisfaction outcome, waiting time from diagnosis to surgery (<6 h – 87% satisfied, 7–12 h – 70%, >13 h – 67%,  $p = 0.03$ ), good communication pre-operatively (87% satisfaction with good communication vs. 30% without,  $p < 0.001$ ), provision of post-operative leaflets prior to discharge (90% vs. 68%,  $p = 0.001$ ) and adequate pain relief (89% vs. 64%,  $p = 0.001$ ) resulted in good patient experience. There was no statistical difference in the overall satisfaction in the clinic follow up group (85%), and the women followed up by telephone (86%).

**Conclusions:** With increasing surgical expertise and advanced diagnostic aids, patient satisfaction has become an important attribute of quality control and health care goal. Good communication and providing information leaflets and adequate pain relief have a positive influence on the woman's reaction to this stressful condition. Our study also suggests that telephone conversation for follow-up is quite an effective means to follow these women after the surgery.

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### Introduction

Ectopic pregnancy is the presence of a pregnancy outside the uterine cavity. The rate of EP is 11 per 1000 pregnancies, with a maternal mortality of 0.4 per 1000 ectopic pregnancies in the United Kingdom [1]. With the use of high-resolution ultrasonography and

improved operator skills, ectopic pregnancies are now diagnosed earlier. The management has shifted from radical to conservative methods, aimed at preserving fertility and minimising morbidity. Advances in laparoscopic surgery have enabled a laparoscopic approach in the majority of patients with tubal EP [2].

The diagnosis of EP has an adverse effect on the quality of life of the affected woman. Women react to early pregnancy loss in different ways and the current management aims at improving patient satisfaction and reducing psychological morbidity. Surprisingly there is only one study published to date, which

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addressed patient satisfaction after management of EP [3]. The experience of pregnancy loss can leave women feeling distressed, overwhelmed, and wanting answers to their questions. At the same time, health care providers often are pressured for time and may not be able to provide this support and information [4].

Women wish to know the cause of their pregnancy loss, when to expect their next menstrual period, when it is safe to attempt another pregnancy, risk of recurrence, and anticipated emotional reactions [5]. According to a meta-analysis of satisfaction literature, humaneness and technical quality of medical care were ranked highly. The bottom five indicators featured aspects of care that reflected the provider's attention to other patient needs and the patient's relation to the system as a whole [6].

The purpose of this study was to evaluate the patient related factors that influence satisfaction rates. Our aim was to determine which factors influence a woman's perception of satisfaction, and ultimately improve the way we help women cope with this distressing situation. We also compared the satisfaction outcomes between the women followed up in a face-to-face clinic with those evaluated after surgery by a telephonic interview. Ultimately if we can avoid a hospital visit follow-up, it may be more convenient to the patient, less distressing, and also cost-effective to the health care provider.

**Materials and methods**

This was a prospective cohort study of all the women treated surgically for EP in a single centre, the early pregnancy assessment unit at Whipps cross university hospital London, over a period of 4 years: January 2009–December 2012. Information relating to the patient demographic characteristics, clinical history and findings, ultrasound, peri-operative and surgical findings, type of surgery, and length of hospital stay were collected prospectively from the units' EP database.

The guidelines for the management of EP are in keeping with that of the royal college of obstetricians and gynaecologists [7]. The

default position in our department is that those who require surgical management of EP are managed laparoscopically unless it is deemed to be clinically unsafe by the attending surgeon. The most experienced surgeon available operates on haemodynamically unstable patients [8]. The operating surgeon debriefs the patient after the procedure. All patients are offered counselling by a trained counsellor if required, and are given an information leaflet. Patients are discharged within 24–48 h after the procedure unless there are clinical indications for prolonged hospital stay. They are then seen in a dedicated EP clinic 6 weeks after surgery. In the last year of the study to further improve patient care a telephone clinic was set up and run by the individuals that had previously been responsible for the dedicated clinic. Those that were not contactable over the telephone were offered a clinic appointment.

The questionnaire we used was devised by a multidisciplinary team consisting of a clinical psychologist, early pregnancy unit nurse and gynaecologists working in early pregnancy units. The questionnaire was tested and validated using a focus group. The questionnaire included questions based on criteria of aspects of care and overall satisfaction with the care provided. This explored the way patients were received, staff willingness to listen, quality of information provided, physical pain after surgery, desire and anxiety about future fertility. These questions were then analysed in relation to socio-demographic characteristics, medical and surgical history, volume of haemoperitoneum, desire for future pregnancy, repeat EP, time interval between the diagnosis and surgery) type of surgery and length of hospital stay after surgery. We considered 800 ml of blood in the peritoneal cavity as significant haemoperitoneum because these women would be classified as having at least category II haemorrhagic shock, having lost between 15% and 30% of their blood volume, as recognised by the American College of Surgeons [9,10].

All data was anonymized and entered into SPSS version 14.0 for Windows. In describing the data, the median and interquartile range (IQR) were used for non-parametric data. Differences in

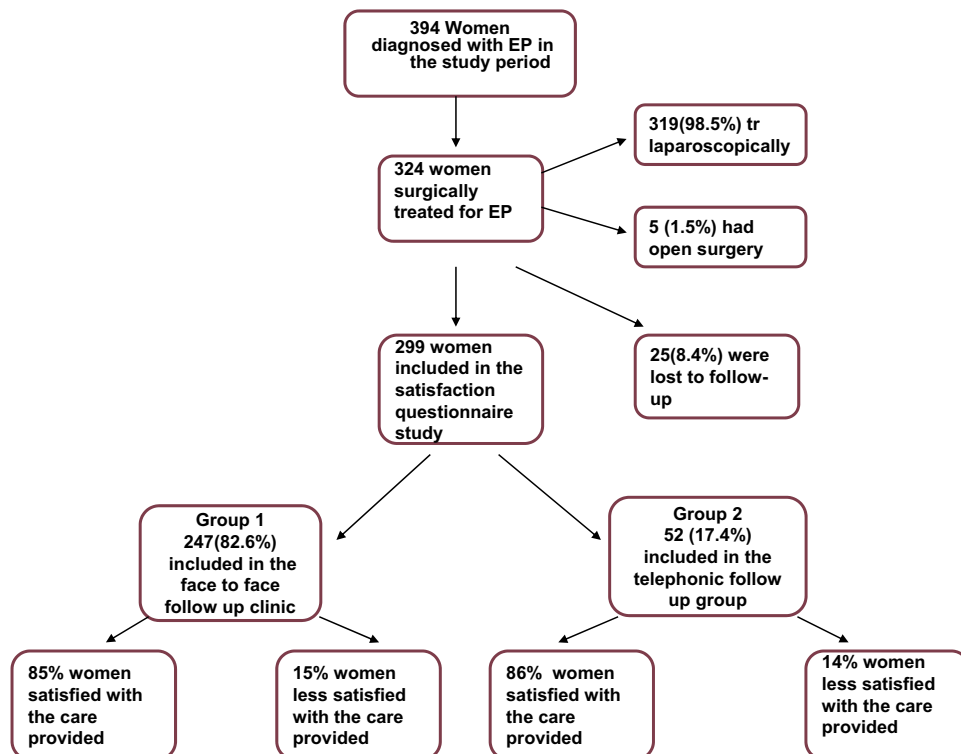


Chart 1. Study design chart.

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