

8-2015

PARTNERING TO IMPROVE PATIENT OUTCOMES: A QUALITATIVE STUDY OF ADULT PATIENT EXPERIENCES WITH ORTHOPEDIC SURGICAL CARE

Sacha L. DeGraffenreid-Yates

Follow this and additional works at: <http://digitalcommons.pittstate.edu/etd>



Part of the [Nursing Commons](#)

Recommended Citation

DeGraffenreid-Yates, Sacha L., "PARTNERING TO IMPROVE PATIENT OUTCOMES: A QUALITATIVE STUDY OF ADULT PATIENT EXPERIENCES WITH ORTHOPEDIC SURGICAL CARE" (2015). *Electronic Thesis Collection*. 78.
<http://digitalcommons.pittstate.edu/etd/78>

This Thesis is brought to you for free and open access by Pittsburg State University Digital Commons. It has been accepted for inclusion in Electronic Thesis Collection by an authorized administrator of Pittsburg State University Digital Commons. For more information, please contact dlwhite@pittstate.edu.

PARTNERING TO IMPROVE PATIENT OUTCOMES: A QUALITATIVE STUDY
OF ADULT PATIENT EXPERIENCES WITH ORTHOPEDIC SURGICAL CARE

A Thesis Submitted to the Graduate School
in Partial Fulfillment of the Requirements
for the Degree of
Master of Science in Nursing

Sacha L. DeGraffenreid-Yates, BSN, RN

Pittsburg State University

Pittsburg, Kansas

August, 2015

PARTNERING TO IMPROVE PATIENT OUTCOMES: A QUALITATIVE STUDY
OF ADULT PATIENT EXPERIENCES WITH ORTHOPEDIC SURGICAL CARE

Sacha L. DeGraffenreid-Yates, BSN, RN

APPROVED:

Thesis Advisor

Jennifer Harris, PhD, APRN
Irene Ransom Bradley School of Nursing

Committee Member

Cheryl Giefer, PhD, APRN
Irene Ransom Bradley School of Nursing

Committee Member

Gregory Belcher, PhD
Technology and Workforce Learning

ACKNOWLEDGEMENTS

This thesis would not have been possible without the support and encouragement I received from my thesis committee members, Dr. Jennifer Harris, Dr. Cheryl Giefer, and Dr. Gregory Belcher. Thank you for the commitment of your time and knowledge to guide me throughout this thesis. A special thank you to Dr. Jennifer Harris, my thesis chair, for your expertise and constant encouragement during this entire process. From our first meeting to defense time your example of excellence has guided me. Your leadership and insight have been essential to my progression throughout this thesis research. I would also like to acknowledge and thank Dr. Janet Zepernick, the time you spent guiding and encouraging me during the final stage of this thesis was essential to completion and has increased my confidence in future research.

A special acknowledgement and an immense amount of gratitude for the support, patience, and understanding my family has given me during this entire process. To my husband, Marty, your patience for all the time I have spent away from our home and your constant encouragement keeps me believing I can accomplish anything. The love and understanding of my two sweet boys, Logan (4) and Madoc (2), always sad to see me “go to school”, but always happy and excited when I walk back through the door. Logan and Madoc I pray you will come to understand how God and the hope I have for your future are what gives me purpose and makes this a valuable process.

Thank you to all of my family and friends who have prayed, encouraged, and been understanding during this process.

PARTNERING TO IMPROVE PATIENT OUTCOMES: A QUALITATIVE STUDY OF ADULT PATIENT EXPERIENCES WITH ORTHOPEDIC SURGICAL CARE

An Abstract of the Thesis by
Sacha L. DeGraffenreid-Yates

The purpose of this study was to explore adult orthopedic surgical patient experiences during their preoperative, perioperative and postoperative care; utilizing the results to discuss specific interactions in care that produced positive or negative outcomes. Partnering with patients to understand shared decision making and patient centered care has been previously researched in literature, and continued research is key to discover effective care practices. The Centers for Disease Control and National Center for Health Statistics (2015) reports total knee and hip joint replacement surgeries of more than one million yearly. The large patient population magnifies the need to understand patient experiences during their orthopedic surgical care and is essential to guide improvements that encourage the patient-healthcare provider partnership. This researcher utilized a phenomenological qualitative design to collect data in a semi structured, topic guided, audio recorded interview until saturation was achieved. Qualitative content analysis was utilized to identify unit meanings

, codes, and themes using the experiences of the 10 study participants. All of the participants had either total knee arthroplasty or total hip arthroplasty at Premier Surgical Institute in Galena Kansas between September 2014 and December 2014, were English speaking and understanding, cognitively intact, and able to meet for the audio recorded interview. A letter of invitation was mailed to 150 potential study participants whom met the criteria, with 10 patients consenting to participate. Four main themes developed that

influenced the patient experience and affected outcomes: healthcare provider attentiveness, patient education, patient need for control, and consideration of the patient's whole life experiences.

TABLE OF CONTENTS

CHAPTER	PAGE
I. Introduction.....	1
Background.....	1
Statement of Research Problem.....	3
Statement of Purpose.....	4
Significance of the study.....	4
Theoretical Framework.....	5
Research Questions.....	6
Summary.....	6
II. Review of Literature.....	8
Introduction.....	8
Communication.....	8
Patient and Healthcare provider partnership.....	11
Behavior Change and Adaptation.....	14
Education.....	16
Value of the patient experience.....	19
Definition of Terms.....	21
Summary.....	22
III. Methodology.....	24
Introduction.....	24
Design.....	24
Sample.....	25
Instrumentation.....	26
Procedure.....	27
Analysis Plan.....	28
Trustworthiness and Rigor.....	30
Assumptions.....	31
Limitations and delimitations.....	31
IV. Results.....	32
Introduction.....	32
Sample and Setting.....	32
Demographic Characteristics of Study Participants.....	34
Interview Themes.....	35
Theme I: Healthcare provider attentiveness.....	35
Theme II: Patient education.....	39
Theme III: Patient need for control.....	41

CHAPTER	PAGE
Theme IV: Consideration of patient's whole life experience.....	42
Summary.....	45
V. Discussion and Recommendations.....	46
Introduction.....	46
Theme I: Healthcare provider attentiveness.....	47
Theme II: Patient Education.....	48
Theme III: Patient need for control.....	49
Theme IV: consideration of patient's whole life experience.	500
Other Considerations.....	52
Conservation Model.....	52
Implications for Nursing.....	53
Strengths and Limitations of Study.....	54
Recommendations for Future Research.....	54
Conclusion.....	55
References.....	57
APPENDICES.....	63
APPENDIX A.....	64
APPENDIX B.....	66
APPENDIX C.....	67

LIST OF TABLES

TABLE.....	PAGE
I. Demographic Information of Study Participants.....	42

Chapter I

Introduction

Background

Adult orthopedic surgical patient experiences are essential to discovery of best care practices. In America's healthcare system patients are benefited and challenged by changes in access to services, advancements in treatments, and current health care reform implementation. The Centers for Disease Control and National Center for Health Statistics (2015) reports total knee and hip joint replacement surgeries of more than one million yearly in America alone. Partnering with adult orthopedic patients to understand how experiences affect outcomes will increase the quality of care administered. The Institute of Medicine of the National Academies (2011) reports the importance of strengthening and empowering, "to become partners and leaders in improving the delivery of care and the health care system as a whole" (p. *ix*). Patient involvement in healthcare education and care plan decision making was a prominent theme discussed by The Josiah Macy Jr. Foundation (2014, p. 5-7). This shift to a more patient-centered approach and a distancing from the practice history of a "...paternalistic model, in which the physician tells the patient what the treatment will be..." (Slover, Shue, & Koenig,

2012, p. 1046). The emphasis on patient partnerships creates an environment for needed adaptation by healthcare providers to continually communicate utilizing a patient-centered approach. The U.S. Department of Health and Human Services (2012) published that 52.2% of persons 18 years and older reported they always felt communication with healthcare providers regarding decision making was present. Effective partnering with patients regarding their orthopedic surgical care decreases opportunity for errors and negative outcomes. Adult patients receiving orthopedic surgical interventions have experiences that can provide insight to needed improvements in care.

In a study regarding communication skills training for healthcare professionals, Norgaard, Kofoed, Kyvik, & Ammentrop (2012) state, “Despite the fact that communication has become a core topic in health care, patients still experience the information provided as insufficient or incorrect and a lack of involvement” (para. 1). Communication and collaboration are basic to the discovery of areas for improvement in adult orthopedic surgical care and the research must involve the patients themselves.

Researchers Bhattacharyya, Freiberg, Mehta, Katz, & Ferris (2009) performed a cross-sectional analysis of hospitals participating in the hip and knee segment of the Center for Medicare and Medicaid Services’ Pay-for-Performance (P4P) Programs that have been championed as a method to improve the quality of health care in the United States. The researchers Bhattacharyya et al (2009) discovered:

P4P programs have a laudable goal of linking reimbursement to quality of care, yet surgical quality is difficult to measure. Proper performance of a total hip replacement requires satisfactory completion of several disparate steps, including proper patient selection and preoperative planning, safe anesthesia, surgical

preparation to prevent infection, surgical approach with minimal trauma, proper technical positioning of acetabular and femoral components, controlled bleeding, appropriate rehabilitation, and prevention of complications such as thromboembolic disease. (p. 529)

Ability to measure quality of care and outcomes for patients is needed, but the importance of patient partnership and involvement must not be disregarded. There will not be an adequate resolution of problems that may occur during orthopedic surgical care until patients are involved in the discovery of areas that need improvement.

Statement of Research Problem

The lack of patient involvement in the healthcare system regarding care improvement is detrimental to improving patient health outcomes for more than a million people per year (Centers for Disease Control, 2014). The Josiah Macy Jr. Foundation reported on their April 2014 conference in Arlington Virginia that brought together patients, leaders of patient advocacy organizations, healthcare educators, and leaders of healthcare organizations to discuss and plan for an increased emphasis on patient involvement in healthcare education and care planning decisions. The need to establish patients as partners in healthcare improvements instead of solely consumers is urgent (Legendra & Witzkin, 2014). During the Josiah Macy Jr. Foundation conference participants cited the September 1978 International Conference on Primary Healthcare where they established that, “The people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare” (Legendra & Witzkin, 2014, p. 2).

Orthopedic surgery and the care of the orthopedic surgical patient is evolving constantly with the development of new procedures, improvements to existing procedures and development of new recovery techniques. Post-surgical hospital stays are much shorter than in years past, a trend in almost all aspects of healthcare. Researchers Legare et al (2012) systematic review states, “Patients’ participation in decision making is associated with better health outcomes and with greater satisfaction with the consultation process” (p. 2). To ensure patients are not negatively affected by changes in orthopedic surgical procedures, techniques, and shorter hospital stays healthcare providers must effectively partner with patients to understand experiences and improve orthopedic surgical outcomes.

Statement of Purpose

The primary purpose of this phenomenological qualitative study was to identify specific areas for improvement in the care of adult surgical orthopedic patients. Collaborating with adult patients to understand their individual experiences related to orthopedic surgical care. Planning and implementation of orthopedic surgical care is more effective when patients understand fully and take part in the process (U.S. Department of Health and Human Services, 2014). Utilization of orthopedic surgical patients’ experiences to improve future health outcomes coincides with the national emphasis to establish patient-centered care (Legendra & Witzkin, 2014). This study has identified areas for improvement and approaches that were successful; reported by patients during their orthopedic surgical care.

Significance of the study

This study is important not only to adult surgical orthopedic patients in Southeast Kansas but to patients worldwide due to the need for increased partnerships in healthcare (Legendra & Witzkin, 2014). The wisdom and understanding of patient experience is a phenomenon to be evaluated and utilized. The patient-healthcare provider partnership provides unique insights into areas of needed improvement. The healthcare providers delivering care must continually identify areas for care improvement; and utilizing the patient experience and values is an important factor (Delbanco & Gerteis, 2013). The benefits of partnering with adult orthopedic surgical patients for care improvement is directly related to positive outcomes. Healthcare providers must be purposeful and committed to viewing the adult orthopedic patient as a partner in their orthopedic surgical care.

Theoretical Framework

This research is guided by the theoretical framework of Myra Estrin Levine and Levine's Conservation Model. The three major concepts of Levine's Conservation Model are wholeness, adaptation and conservation (Alligood, 2014). The development of collaboration works toward wholeness for the patients and the adaptation or process of change occurs as the patient retains their integrity. The Conservation Model specifically speaks of the need for "... interactions and interventions that are intended to promote adaptation and maintain wholeness" (Alligood, 2014, p. 207). The capacity to adapt is described within Levine's Conservation Model as the organismic response. Included in the organismic response is perceptual awareness as the ability to gather and maintain safety, converting the experience into a meaningful one (Alligood, 2014).

Patients undergoing orthopedic surgery must be given the opportunity to complete the healing process, become whole and well adapted through conservation of integrity (Alligood, 2014). Assisting the adult orthopedic patient to learn and develop new adaptation techniques in preparation for and throughout the orthopedic surgical process allows for a greater conservation of energy and personal integrity thereby achieving wholeness (Alligood, 2014). By valuing the partnership with adult orthopedic surgical patient's healthcare providers can maintain a more constant awareness of the needed adaptations of care delivery for more positive outcomes.

Too often healthcare providers feel that the best course of treatment or recovery in orthopedic surgical care is the one planned solely by the healthcare provider. Evidenced based practice should guide treatment; although the best course has to include the patients' values and desires, otherwise achieving desired outcomes is less possible (Legare et al., 2012). Levine noted that the definition of health will change over time for each individual and therefore the consistency of partnerships between patients and healthcare providers is essential to continued care improvement (Alligood, 2014).

Research Questions

The research questions for this study were:

1. What experiences during an orthopedic surgical patient's care provide insight to needed changes in practice?
2. What aspects of the orthopedic surgical patients' care experience was unclear or confusing?
3. What experiences made orthopedic surgical patients feel part of the decision making process in their partnership with healthcare providers?

Summary

The need for increased partnerships between healthcare providers and adult orthopedic surgical patients is established. Researchers Delbanco and Gerteis (2013) state patients "... want to be able to trust the competence and efficiency of their care givers" (para 2). The problem of lack of partnerships and involvement of patients regarding care planning and implementation is also understood. Partnering with adult orthopedic surgical patients to discover areas for needed care improvement and education is not merely to satisfy consumers, but basic to the conservation of integrity (Alligood, 2014).

Researchers Delbanco and Gerteis (2013) found that what patients value may differ from what healthcare providers recommend and stated "Shared decision-making approaches can help clinician and patient, together, clarify options, outcomes, uncertainties, and values" (para 6). Levine's Conservation Model will provide the necessary framework to look at all aspects of the patient experience and maintaining wholeness through integrity (Alligood, 2014). Discovering the aspects of care that are currently not in line with the conservation of integrity or the maintenance of wholeness (Alligood, 2014). Partnership between adult orthopedic surgical patients and healthcare providers is essential to improving patient health outcomes holistically.

Chapter II

Review of the Literature

Introduction

Before a study on partnering with orthopedic surgical patients for care improvement can be done, it is important to examine the literature and understand what has been previously studied. The Macy Foundation Conference discussed, "... a future in which individuals, families, and communities are understood to be the very reason our healthcare system exists, and that those who are caring, teaching, learning, or otherwise working within the system must partner fully..." (Legendra & Witzkin, 2014, para. 4). The United States healthcare system is consistently evolving, caregivers and care receivers need to be aware, involved and engaged to ensure continual improvement in care.

This review of literature will attempt to create a background of information on the concepts of communication, patient and healthcare provider partnership, behavior change, education and the value of the patient experience.

Communication

When reviewing the literature for the importance of communication, uses and application are pertinent in all aspects of care delivery. Emphasis on communication is a common theme in today's healthcare literature. Norgaard, Kofoed, Kyvik, and

Ammentorp (2012) conducted a study assessing patient satisfaction before and after healthcare providers participated in communication skills training by utilizing a twelve-point questionnaire pre and post training. The researcher's state "... patient satisfaction is directly statistically relational to communication from healthcare providers regarding care and outcomes..." (Norgaard et al., 2012, p. 698). This is a generally accepted theme but we must consider communication skills as having great value (Norgaard et al., 2012). The researchers report "This study shows that patients' satisfaction with the information, continuity and care offered by healthcare professionals can be improved by training staff in patient centered communication" (Norgaard et al., 2012, p. 703). This study suggests the training of healthcare providers in patient centered communication should be standard for care. Reflecting and evaluating the communication skills possessed by individuals and professionals allows for improved understanding in all aspects of interactions related to healthcare delivery.

Wye, Shaw and Sharp (2009) discuss the concepts of patient led and evidenced-based healthcare in regards to controversial treatments and patient's choice. Interviews were conducted and recorded with a case study methodology used. The need for communication between healthcare professionals and patients regarding care is essential when assessing the use of more alternative or controversial treatments was derived (Wye, Shaw, & Sharp, 2009). Professionals need to reduce the power of influence that they carry with evidence-based standards and acknowledge the legitimacy of patient preferences, views and alternative sources of evidence (Wye, Shaw, & Sharp, 2009). This does not intend to reduce the importance of using evidenced based research and practice. The theme of acceptance and acknowledgement to foster further communication is the

means to improving partnerships between patients and healthcare providers for care improvement.

Slatore et al. (2012) conducted a qualitative analysis utilizing “Ethnographic observations of 315 hours of interactions and 53 semi structured interviews with 33 nurses in a 26-bed cardiac-medical intensive care unit in an academic hospital and a 26-bed general intensive care unit in a Veterans Affairs hospital in Portland, Oregon” (para. 3). Applying the five domains of patient centered care to categorize interactions and reactions. The five domains are detailed by the researchers as: “...the biopsychosocial perspective, with a focus on information exchange; the patient as person; sharing power and responsibility; the therapeutic alliance; and the clinician as person” (Slatore et al., 2012, p. 411). The researchers reported “Most communication occurred in the domains of biopsychosocial information exchange, patient as person, and clinician as person. Nurses endorsed the importance of the domains of shared power and responsibility and therapeutic alliance but had relatively few communication interactions in these areas” (Slatore et al., 2012, p. 410). Interestingly in this study the theme developed of the role of translator between physician and patient was felt by the nurses, not literal language but the need to improve the communication to ensure patients understanding.

The U.S. Department of Health and Human Services [HHS] Healthy People 2020 objective in health communication lists the importance of “...health literacy, patient’s satisfaction with healthcare provider’s communication skills, individual’s involvement in their healthcare decision making, receipt of provider’s recommendations for personalized healthcare resources and social support” (2014, table 3). HHS Healthy People 2020 also importantly addresses the Health Information technology objectives by listing “...internet

access, electronic personal health information sources, electronic health record, access to online health information, users of health information technology, best practices in health protection messages, social marketing in health promotion and disease prevention” (HHS, 2014, table 3).

Effective communication with the presence of technology takes on another element for increased collaboration. Utilizing electronic communication and education can increase the potential for care improvement. The ability through technology to reach more patients and affect change without the constraints of an office visit or inpatient encounter. Author Boykins (2014) writes regarding the need for schools of nursing to ensure education and proper nurse preparedness to communicate effectively. The “core competencies” Boykins (2014) speaks to are “Communication tools including patient centered care, interprofessional collaboration and informatics are important for improving patients outcomes and delivering high quality and safe care” (p. 44). Communicating in care coordination, partnering and discovering areas for improvements is essential to all patients and healthcare providers.

Patient and healthcare provider partnership

The importance of partnering with patients for care improvement is to reduce poor outcomes. The unnecessary adverse events surrounding orthopedic surgery and all healthcare must be reduced and eradicated. Unbeck, Dalen, Muren, Lillkrona & Haˆrenstam (2010) conducted a three-stage retrospective review identifying the impact of patient safety risk factors and adverse events in 395 orthopedic inpatients during a two-month time period. The researchers described sixty of the 395 orthopedic inpatients experienced a total of 65 healthcare related adverse events during the study period

(Unbeck et al., 2010). In these 65 adverse events, 34 were classified as preventable, 34 were severe, and 15 were judged to be both preventable and of major severity (Unbeck et al., 2010). Some of the most commonly found adverse events included wound infections, pneumonia and delayed detection of urinary retention (Unbeck et al., 2010). The conclusion related the need for education and adherence to existing protocols and the importance "... in orthopaedic care to continue to identify the patients and their complications, where risks occur in the healthcare processes, and deepen the knowledge about underlying causes" (Unbeck et al., 2010, p. 676). Partnering with patients to increase understanding of poor health outcome prevention.

Hunt, Moore and Sherriff (2012) conducted a study with 29 rural patient participants placed in focus groups to assess perceptions regarding care planning and relationships with healthcare providers. The researchers discussed themes that developed during the analysis of data: increased patient satisfaction through having 'ownership' over their health care, decreased pressure on health resources and improved health outcomes due to increased patient commitment to goals where all identified (Hunt, Moore, & Sherriff, 2012). The researchers derived, "More work is needed to create a health culture in which patients want to manage their own health and can develop a relationship with their health professional that allows them to achieve this" (Hunt et al., 2012, p. 26). Hunt, Moore & Sherriff (2012) reported discussions in focus groups where study participants described feeling unimportant and belittled by the healthcare provider. Healthcare providers must evaluate all prejudice that may negatively affect communication with patients.

Poochikian-Sarkissian, Sidani, Fergusin-Pare, & Doran (2010) utilized a descriptive correlational design with repeated measures to study "...patients' perception of the extent to which the dimensions of Patient Centered Care were provided by nurses, and the relationships of these dimensions to patient outcomes" (p. 16). The researchers detailed how "...it is important for all health care providers to incorporate the patient's perspective while providing care in order to improve health care quality and increase satisfaction" (Poochikian-Sarkissian et al., 2010, p. 16). Results from the study by Poochikian-Sarkissian et al (2010) indicated "patients perceived that nurses encouraged patients to participate in their care to a limited extent" (p. 20). Yet researchers reported the nurses involved in the study felt they did consistently encourage patient involvement in care. Outcome findings also reflected previous studies findings that the partnership between Patient Centered Care and outcomes "...was associated with high levels of self-care" (Poochikian-Sarkissian et al., 2010, p. 19).

Holzel, Kriston, & Harter (2013) developed and tested a model, "...linking decision-making in medical encounters to an intermediate and a long-term endpoint (p. 1). Researchers Holzel, Kriston, & Harter (2013) tested the hypothesis:

Physicians are more likely to involve patients who have a preference for participation and are willing to take responsibility in the medical decision-making process, increased patient involvement decreases decisional conflict, and lower decisional conflict favourably influences patient satisfaction with the physician. (p. 1)

Data collection by the researchers was reported, "...6,542 primary care patients were contacted in July 2007. Of the 2,450 patients (37.5%) who returned the

questionnaire, a total of 1,913 complete data sets could be identified” (Holzel et al., 2013, p. 3). Researchers reported results consistent with hypothesis previously stated, “...higher patient involvement clearly lowered decisional conflict” (Holzel et al., 2013, p. 5).

Researchers Ferreira et al (2013) refer to the partnership with patients as a “therapeutic alliance” and utilized a retrospective study to ascertain if the partnership was an indicator of outcomes for physical therapy patients with chronic low back pain (p. 470). Ferreira et al (2013) explain:

The 3 main components of the therapeutic alliance construct as being: (1) the therapist patient agreement on goals, (2) the therapist-patient agreement on interventions, and (3) the affective bond between patient and therapist.

Consistently, studies have shown that higher levels of therapeutic alliances are associated with better health outcomes in medicine and psychology. (p.471)

Researchers noted the perceived quality of interactions between healthcare providers and patients predict measures of physical functioning (Ferreira et al., 2013).

As discussed patient and health care provider partnerships directly affect the physical functioning, behavior change and adaptation abilities of the patient population. Understanding the research related to effective behavior change and adaptation is essential to understand ways to foster this valuable partnership.

Behavior Change and Adaptation

Orr and Plaut (2014) conducted a synthetic review of the intersection of quantum health behavior change and cognitive science. They define cognitive science as, “the study of the mind as an information-processing system” (Orr & Plaut, 2014, p. 404). Comparatively Orr and Plaut (2014) define the quantum behavior change paradigm as:

The possibility that health behavior may be governed by dynamic non-linear and chaotic processes in addition to, or instead of, more rational, linear processes.

This idea is central to work on “catastrophic” pathways to health behavior change, where behavior change is characterized by sudden and dramatic shifts. (p.405)

This concept of health behavior is allowing for more adaptation and application to the individual. Levine’s Conservation Model defines adaptation as “...a process of change whereby the individual retains his integrity within the realities of his internal and external environment” (Alligood, 2014, p. 206). Orr and Plaut (2014) go a step further in evaluating years of behavior change research, “What does this discussion of health behavior mean? Perhaps it means that a set of yes/no answers do not, in any respect, capture the complexity of what is dynamic about human health behavior” (p. 412).

Williams-Piehot, Sirois, Bann, Isenberg, & Walsh, (2011) researched the possible link between Complementary and Alternative Medicine use and positive health behavior change through a mixed methods study. The researchers reflect on the importance of primary and secondary prevention of disease and the effectiveness of the patient-provider relationship facilitating the behavior change (Williams-Piehot et al., 2011). It is important to understand what motivates individuals to complete health behavior changes. Williams-Piehot et al (2011) discovered “... supportive treatment environment and practitioner relationship and client openness and readiness to change are critical factor to promote client selfcare and lifestyle changes in the context of receiving Complementary and Alternative Medicine treatment” (p. 29).

Mettler et al (2014) examined the potential for behavior change through wellness coaching. The researchers aimed “to identify client priorities prior to wellness coaching,

and examine motivational improvements for health behaviors on follow-up” (Mettler et al., 2014, p. 83). Wellness coaching is described as a “...partnership that focuses on the client taking action towards achieving optimum health”, through education and motivational meetings to “...develop client awareness, responsibility, and motivation for wellness-related behavior change” (Mettler et al., 2014, p. 84). Researchers report results that “...participants advanced their motivational readiness for change in mental/emotional fitness, from 68.7% at baseline in the action or maintenance stage, to 94.8% at follow-up” (Mettler et al., 2014, p. 90). Behavior change that provides for attainment of integrity through adaptation and ensuring wholeness come when readiness to learn and education coincides.

Education

Tung, Cooke and Moyle (2012) reported on their descriptive exploratory qualitative study, observing how older orthopedic patients maintained and improved self-efficacy after discharge. The researchers cited how “...self-efficacy plays an important role in a personal competency development system, which determines how people feel, think, are motivated and behave” (Tung, Cooke, & Moyle, 2012, p. 1218). Noting that there is often a reduced level of confidence and motivation in patients following discharge from orthopedic surgery (Tung et al., 2012). Conclusions were drawn that education from healthcare professionals relating to adaptive strategies and goal setting played an important role (Tung et al., 2012). The positive attitude and availability of support from individual social networks and community services also greatly influenced the outcomes (Tung et al., 2012). Researchers Tung et al (2012) also discovered the theme “Nurturing self-efficacy through working with others” (p. 1220). The

encouragement and relationship created a confidence in the orthopedic surgical patients allowing for care improvement. These concepts are essential to predicting need and improving patient health outcomes.

Wong, Chan and Chair (2009) report on their study of the effectiveness of a "... pain management educational intervention on level of pain, anxiety and self-efficacy among patients with musculoskeletal trauma and consequent orthopedic surgery" (p. 1). The common standards of preoperative education were discussed and the generally effective nature of the practice. The emphasis on increased education, specifically a 30-minute intervention highlighting pain management, coping strategies and breathing relaxation techniques was utilized in this study. This study was completed by a total of 125 patients, the experimental group (n=63) reported statistically significantly lower levels of pain when compared "...between the groups across the four time periods (T0–T3), $F(3,121) = 4.17, P = 0.008$, partial eta square, 0.02 . A post hoc Tukey test showed a significant statistical effect ($P < 0.001$) between days 2 and 4 as well as between days 4 and 7", less anxiety "Pair-wise comparison using the Tukey test showed a statistically significant effect ($P < 0.001$) between days 2 and 4 as well as between days 4 and 7" and better self-efficacy" ... $F(1,123) = 4.25, P = 0.048$..." during hospitalization as compared to the control group (62) (Wong et al., 2009, p. 1124-1125).

The metasynthesis of sixteen papers conducted by Perry et al (2012) "...explored the older adults' perceptions of being discharged following orthopaedic surgery and found four key themes portrayed by participants. These themes were: Mental outlook, Loss of independence, Functional and activity limitations, and Coping with pain" (p. 275). Perry et al (2012) reported "Community involvement through voluntary work or

educational classes can make older adults feel valued” (p.275). The importance of “Consistent reinforcement of clear information may help older adults feel more confident to cope with these problems” was included by Perry et al (2012) as implications for practice and guidance (p.267).

Foisy (2013) utilized a Transforming Care at the Bedside Model to decrease falls for orthopedic surgical patients with a femoral nerve block (FNB), “a multifaceted, strategic practice and educational bundle was implemented, resulting in a 75% decrease in falls among patients with FNB” (p. 246). It is explained how important patient and family education is to preventing falls. Ensuring proper placement of call light and the understood need to call for assistance is vital. Focus by healthcare providers and all staff efforts in reducing falls with continual education is imperative. Pt education involving a tip sheet for patients and family along with room signage address fall prevention within this interventional study.

Shaw, Richards, Wood, & Calvert researched and observed the intervention of “...Integrated Care Pathways (ICP)...” to streamline orthopedic nursing and assess cost effectiveness in New Zealand (2014, p. 23). The researchers explain “The ICP provides a plan for patient care and, at the same time, provides education for staff” (Shaw et al., 2014, p. 24). The emphasis on education and care planning is a common theme. Patient satisfaction was not measured in this study. Shaw et al (2014) reports the Integrated Care Pathway “...achieved its goals of providing high quality, safe care to people undergoing routine surgery, facilitating nurses' and patients' ongoing education, and decreasing length of stay” (p. 25).

Education and improving outcomes is directly relational. The time constraints inflicted in healthcare situations must not effect this important element to care improvement. The Institute of Medicine (2011) report *The Future of Nursing: Leading Change, Advancing Health* speaks to the need and purpose that Advanced Nursing:

Can fill such new and expanded roles in a redesigned health care system. To take advantage of these opportunities, however, nurses must be allowed to practice in accordance with their professional training, and the education they receive must better prepare them to deliver patient-centered, equitable, safe, high-quality. (p. 13)

The value of patient's experiences and the influence on outcomes is equally as important. The education effects the experiences of the patients and healthcare providers involved.

Value of the patient experience

Suhonen et al. (2011) studied nurse's perceptions of individualized care internationally and stated, "The principle of individualized nursing care is broadly accepted worldwide among healthcare professionals" (p.2). They describe the essential task of promoting patient participation and decision making in their care. They discussed how patients' clinical and personal life situations and background have an effect on this reaction to hospitalization and care delivery (Suhonen et al. 2011). Patients feel engaged in the caring relationship when they are valued individually. Patient care cannot be exclusively standardized. The importance of considering the patients' experiences, emotions at that particular time and adapting care standards are essential to increase improved outcomes.

Chetty and Ehlers (2009) descriptive and quantitative survey was conducted to study the important aspect of patient's perceptions regarding preoperative orthopedic surgery education. The value of the patient's experiences post operatively related to pre-operative education was assumed. Chetty and Ehlers (2009) report "...pre-operative information decreased the anxiety levels about their impending surgery of 39 (78.0%) respondents" (p. 58). Chetty and Ehlers (2009) reported that most patients "...understood the information, 16 (32.0%) found it difficult to understand medical terms and 27 (54.0%) would have appreciated more opportunities to ask further questions" (p. 59). The correlation between patient satisfaction and education was again derived.

Heikkinen, Salantera, Leppanen, Vahlberg, and Leino-Kipi (2012) evaluated the patient experiences in two different educational formats. Internet based and face to face pre-operative educational programs were studied in elective orthopedic surgical patients. The authors concluded there was not a statistically significant difference in the emotions between the two groups in differing educational programs (Heikkinen et al., 2012). The experiences and emotions during the operative and post-operative periods varied but did not significantly reduce the overall emotions of participants (Heikkinen et al., 2012). Patients' experiences are unique and must be studied, noted and used to improve health outcomes.

Flierler, Nubling, Kasper, & Heidegger (2013) assessed, "...patients' preference to be involved in medical decision making and its influence on patient satisfaction..." (p.713). The researchers utilized two previously validated questionnaires to study 197 pairs of patients and anesthetists. Flierler et al (2013) discovered:

One hundred and eighty-six patients (94%) wished to be involved in shared decision making. One hundred and twenty-two patients (62%) experienced the exact amount of shared decision making that they wanted; 44 (22%) were slightly more involved and 20 (10%) slightly less involved in shared decision making than they desired. (p. 713)

Overall patient satisfaction with decision making was high (88%) and 90% reported shared decision making was a high priority to them (Flierler et al., 2013, p. 718). The researchers "...recommend that, if in doubt, decisions should be shared with your patient; too much shared decision making does not reduce satisfaction, while too little tends to" (Flierler et al., 2013, p. 721).

Definition of Terms

The following is a list of definition of terms that are found in this research study:

Healthcare Provider: Medical Doctors and Doctors of Osteopathy, Advanced Practice Nurses, Physicians Assistants, Chiropractors, Podiatrists and those persons engaged in a postgraduate training program which is approved by the Kansas Board of Healing Arts (Kansas Health Care, 2014).

Adaptation: Process of change whereby the individual retains their integrity within the constructs of their internal and external environment (Alligood, 2014, p. 206).

Behavior: "The manner of conducting oneself, anything that an organism does involving action and response to stimulation, the response of an individual, group, or species to its environment" (Merriam-Webster, 2014, para. 3)

Communication: “The act or process of using words, sounds, signs, or behaviors to express or exchange information or to express your ideas, thoughts, feelings, etc., to someone else” (Merriam-Webster, 2014, para. 2).

Conservation: “to keep together”, “...Describes the way complex systems are able to continue to function even when severely challenged” (Alligood, 2014, p. 207).

Partnering: “To be or become a partner, the joining with someone or something as a partner, to work together” (Merriam-Webster, 2014, para. 2).

Patient Experience: Patient being a person who is experiencing their life process, then relaying the information as only the one experiencing the process can (Alligood, 2014, p. 209).

Wholeness: “Wholeness emphasizes a sound, organic, progressive mutually between diversified functions and parts within an entirety, the boundaries of which are open and fluent” (Alligood, 2014, p. 206).

Summary

These concepts of communication, patient and healthcare provider partnership, adaptation, behavior change, education, and the value of the patient experience are important to consider in today’s world of healthcare. Patients entering healthcare provider offices often come with knowledge and concern from internet sources that may not be valid. Healthcare providers who are prepared and aware of how societal and cultural influences effect patients have an advantage in providing care.

Adjusting how healthcare providers view patients is important, to see them as people with individual values and to partner with them to improve their health. The review of literature reveals common themes and previous areas of communication,

previous studies incorporating patients in improving and planning care. The adaptation to changes, behavior change concepts and the value of the patient experience helping to guide continued care improvement.

Chapter III

Methodology

Introduction

The primary purpose of this phenomenological qualitative study was to identify specific areas for improvement in the care of adult surgical orthopedic patients through their lived experience. To partner with adult patients to understand their individual experiences during orthopedic surgical care. The research questions for this study included:

1. What experiences during an orthopedic surgical patient's care provide insight to needed changes in practice?
2. What aspects of the orthopedic surgical patients' care experience was unclear or confusing?
3. What experiences made orthopedic surgical patients feel part of the decision making process in their partnership with healthcare providers?

Design

This qualitative study utilizing raw data from self-report with an emergent design (Polit & Beck, 2012). Qualitative research tends to be holistic, "striving for an

understanding of the whole” (p. 487). Self-report is the raw data collected through the questioning of people, asking for study participants experiences related to the problem (Polit & Beck, 2012, p. 188). An emergent design is one “... that materializes during the course of data collection” (Polit & Beck, 2012, p. 62). The research methodology used for this study was phenomenology with influences from hermeneutics. Phenomenology emphasizes importance on the lived experiences of humans, while hermeneutics uses the lived experiences as a tool for interpretation and increased understanding of those experiences (Polit & Beck, 2012). The aim of this study was to identify specific areas for improvement in the care of adult surgical orthopedic patients. Partnering with adult surgical orthopedic patients to report personal lived experiences related to their care, to interpret these individual orthopedic patient experiences, and identify areas that would improve patient health care outcomes. Guided by qualitative emergent research design the adult orthopedic patient experiences caused this study to continually evolve “...based on the realities and viewpoints of the participants...” (Polit & Beck, 2012, p. 487).

Sample

Study participants were recruited from the adult surgical patient population at Premier Surgical Institute (PSI), an orthopedic surgical hospital in Southeast Kansas. Maximum variation sampling was utilized to ensure a purposeful selection, diverse background, and study participants of differing viewpoints (Polit & Beck, 2012). Eligibility criteria for inclusion included: age group categories (50-59), (60-69), (70-81), English speaking and understanding, cognitively intact, elective singular total knee arthroplasty or elective total hip arthroplasty within the last three months prior to Internal Review Board (IRB) approval, consent to be a part of this research study, and the ability

to meet for interview. There was no risk or benefit identified for participation in this research.

Sample size was guided by data saturation for phenomenology research, defined by Polit and Beck (2012), “sampling to the point at which no new information is obtained and redundancy is achieved” (p. 521). After study participants were identified from PSI medical records, from the most recent three months to IRB approval date. Medical charts were pulled and reviewed for inclusion criteria. Recruitment was conducted via written letter of invitation with telephone follow-up call within one week from letter. Anticipated response rate was approximately 50% of those contacted, with actual response rate of 7%. For phenomenology research a minimum of 10 participants is generally utilized, but maximum variation sampling of up to 15 participants would be accepted if responses had reached this number. A total of 10 study participants consented to be part of this research. Five letters of invitation were returned via mail as undeliverable, with follow up calls unsuccessful. While the remaining 135 letters of invitation and follow up calls did not result in participation, two reported lack of time to participate, and the other 133 either did not respond or declined to participate. An audit trail of all data was kept for a six-month period following completion of research.

Instrumentation

This researcher conducted a semi structured topic guided interview at a location and time of the study participant’s convenience. Opportunity for interview was offered to study participants at the time and location surrounding post-surgical follow up visit for added convenience if applicable and to increase potential participation. Prior to the start of the interview, informed written consent was obtained and the study participant was

reminded they may withdraw from the study interview at any time without prejudice. Statement of length of interview was determined by study participant time constraints, thirty minutes to two hours was the range of actual interviews. Demographic data including: age, gender, date surgery received and type of surgery was collected at the start of the interview. A topic guide (Appendix A) was utilized, guided by the research questions. The semi structured interview allowed study participants to use their own words, tell stories and allowed for probing questions from the interviewer to elicit more detailed information when indicated (Polit & Beck, 2012). Prior to conclusion of interview this researcher reviewed information collected with the study participant to ensure full understanding, disclosure, and provide opportunity for clarification. Interviews were not scheduled consecutively to allow for maximum data collection.

Procedure

After proposal approval from the Pittsburg State University Committee for the Protection of Human Research Subjects was given, then Internal Review Board (IRB) approval was obtained from Premier Surgical Institute; prior to collection of data. Verbal statement of interest to approve this study was received in October of 2014 from the Chief Executive Officer of Premier Surgical Institute. All potential study participants were given an explanation of the study and its purpose in a mailed letter of invitation.

Those who chose to participate were informed that they could withdraw from the study without prejudice at any time. Verbal and written consents were obtained prior to participation. All face to face interviews were audio recorded with observational notes taken consecutively and transcribed exactly as recorded. Post transcription comparison was utilized by the researcher to ensure accuracy. Polit & Beck (2012) describe, “The

interviewer's job is to encourage participants to talk freely about all the topics on the guide and to tell stories in their own words" (p. 537).

Study participants were informed that confidentiality and privacy of data will be maintained by changing of name to an archival code (TR001-TR010). After the study was concluded audio data along with consent forms will remain in a locked Pittsburg State University Irene Ransom Bradley School of Nursing cabinet for six months. After the six-month time frame has concluded all recorded data will be destroyed. The research study began December 2014 and ended May 2015.

Study participants were informed that the study will be made public in the Pittsburg State University Axe Library, the Pittsburg State University Irene Ransom Bradley School of Nursing library, and potentially published.

Analysis Plan

After transcription of audio recorded interviews were completed a thematic analysis was conducted. Polit and Beck (2012) cite, "A theme is an abstract entity that brings meaning and identity to a current experience..." (p. 562). Research questions guiding the semi structured conversational interview were:

1. What experiences during an orthopedic surgical patient's care provide insight to needed changes in practice?
2. What aspects of the orthopedic surgical patients' care experience was unclear or confusing?
3. What experiences made orthopedic surgical patients feel part of the decision making process in their partnership with healthcare providers?

Qualitative content analysis will assist in guiding this researcher "... to identify prominent themes and patterns among the themes" (Polit & Beck, 2012, p. 564). Van Manen's (1990) method of phenomenological analysis will be also be utilized to "...combine descriptive and interpretative phenomenology" (Polit & Beck, 2012, p. 567). Van Manen's approach allows researchers to "try and grasp the essential meaning of the experience being studied" (Polit & Beck, 2012, p. 567). Polit and Beck (2012) report "According to Van Manen, thematic aspects of experience can be uncovered or isolated from participants' descriptions of the experience by three methods: (1) the holistic approach, (2) the selective (highlighting) approach, and (3) the detailed (line by line) approach" (Polit & Beck, 2012, p. 567). Polit and Beck further detail the descriptions:

In the holistic approach, researchers view the text as a whole and try to capture its meanings. In the selective approach, researchers highlight or pull out statements or phrases that seem essential to the experience under study. In the detailed approach, researchers analyze every sentence. (p.567)

Van Manen states, "Through this process, essential themes are discovered" (Polit & Beck, 2012, p. 567). Polit and Beck explain, "Qualitative content analysis involves breaking down data into smaller units, coding and naming the units according to the content they represent, and grouping coded material based on shared concepts" (2012, p. 564). Percentages of the respondents in the different themes identified will also be reported.

Study participants are described and displayed using descriptive statistics. Selected demographic characteristics were gender and age category. The selected

variables identified for study participant inclusion were specific orthopedic surgery received along with the month and year, to ensure inclusion criteria was met.

Trustworthiness and Rigor

The use of the term healthcare providers was utilized to describe all providers the study participants may have had contact with during their entire experience. This decreased the bias in reporting and allowed for study participants to recall all aspects of their experience without influence of which interactions to report.

Bracketing was also utilized and is described by Polit and Beck as, “The process of identifying and holding in abeyance reconceived beliefs and opinions about the phenomenon under study” (2010, p. 495). A reflective journal assists with bracketing and allowed this researcher to discuss, prepare, and evaluate the interactions “...in an effort to confront the data in pure form” (Polit & Beck, 2012, p. 495). In the reflective journal the researcher recorded and evaluated instances during interviews that were successful in eliciting purely reported experiences by the study participants. To ensure dependability observations and non-verbal language was noted during the interviews and recorded in the reflective journal. This was key to ensuring influence was not present from the researcher and done in preparation for each interview. Approaching each interview desiring to simply hear the study participant tell their story and keep in check any desire to interpret their experience for them. This was extremely important to maintain credibility and perform the research ethically. Credibility was also maintained through reviewing responses with participants at conclusion of interview and allowing for any clarifications to be discussed immediately. Confirmability obtained through member checking and committee meetings. Transferability achieved by through description of

participant experiences and perceptions. Authenticity supported by the use of participant quotes and experience descriptions.

Assumptions

The assumptions to this research study include:

1. Study participants will answer all questions truthfully.
2. The topic guide for conversational interview is valid and allows for phenomena to develop and answer the research questions.
3. Thematic analysis used will accurately assess the data collected.
4. Patients desire to partner with healthcare providers in care planning and decision making.

Limitations and delimitations

The following are limitations to the study:

1. The findings cannot be completely generalized to all patients and healthcare professionals, as this study will only look at adult surgical orthopedic patients.
2. The time constraints set by the researcher as well as the study participants, may limit the population of study participants.
3. Budget constraints may limit the researcher and study participants' ability to participate if long driving distances are required.

The following are delimitations of the study:

1. The researcher will not influence study participants answers to topic guide prior to or during the interview.
2. This research study will not implement any intervention.

Chapter IV

Results

Introduction

Utilizing the methodology detailed previously resulted in study participants described experiences of their orthopedic surgical care. During detailed content analysis of the data, four main themes developed that influence the orthopedic surgical patient experience and affect outcomes: healthcare provider attentiveness, patient education, patient's need for control, and consideration of the patient's whole life experience. The sample and setting along with all discovered themes are resulted below.

Sample and Setting

The sample consisted of 10 adult orthopedic surgical patients who had either a total knee or hip arthroplasty between September 1, 2014 and December 31, 2014. After verbal and written consent were obtained, adult orthopedic surgical patients met with this researcher for audio-recorded, topic-guided interviews.

As seen in Table I, there were five male and five female study participants. Nine study participants underwent total knee arthroplasty and one had a total hip arthroplasty; one study participant elected to have left and right total knee arthroplasty approximately six weeks apart.

All audio recorded interviews were conducted at a location chosen by the study participant. All study participants elected to be interviewed at their residences and selected the date and time. This setting allowed for maximum comfort and privacy for each study participant.

Table 1

Demographic Characteristics of Study Participants

Characteristics	Number of Study Participants
Age Category	1 (50-59)
	5 (60-69)
	4 (70-81)
Gender	5 Male
	5 Female
Surgery	10* TKA
	1 THA

Note. TKA= Total Knee Arthroplasty, THA= Total Hip Arthroplasty

*One study participant received right and left Total Knee Arthroplasty approximately six weeks apart

Interview Themes

Study participants reported many experiences that affected their outcomes during orthopedic surgery. During content analysis of the data, four main themes developed that influence the orthopedic surgical patient experience and affect outcomes: Healthcare provider attentiveness, patient education, patient's need for control, and consideration of the patient's whole life experience. While communication did not emerge as a distinct theme in this data, communication was present as an implicit theme in almost every participant response. As the literature review outlined communication in past research has always led to a more desirable experience and is essential to care delivery. This will be discussed more in chapter five. The four themes that emerged are defined below.

Theme I: healthcare provider attentiveness.

In this study, the theme of healthcare provider attentiveness emerged in the form of comments addressing timely response to patient needs, healthcare providers exhibiting behaviors that create an impression of being emotionally aware and mentally engaged during patient consultation, and providers creating opportunities for the patient to participate in the decision-making process. In this study, healthcare provider attentiveness was consistently associated with positive experiences, while reports of negative experiences consistently included references to lack of attentiveness.

For the participants in this study, timeliness and predictability had the greatest impact (80% of respondents) during the in-patient portion of their treatment and was particularly important in the form of daily care, such as timely response to needs for toileting (30% of respondents) and timely delivery of pain medication (40% of respondents), and predictability of physician rounds (40% of respondents), which allowed

patients to expect and plan for daily interaction with their physician. Study participant responses to questions of meeting expectations in timeliness of response were frequently “excellent” and “great.” It was clear that when expectations were met, elaboration was not as extensive; when expectations either were not met or were exceeded, the experience was more richly described. The perception of healthcare provider attentiveness and timely response was reflected during pain management care. For example, one study participant commented about the process of finding an appropriate pain medication, “the first one might have made me sick, but...they kept changing trying to find one that didn’t, and so it was a good experience.” Yet another study participant, when asked if there was anything he would have changed or if experience had been especially clear or unclear, stated “The nurses were very helpful; I mean, if I needed something they got it, if I needed something for pain they got it.”

Another important aspect of healthcare provider attentiveness is the predictability of the physician’s visits during the inpatient stay. Predictability associated with healthcare providers being emotionally aware and mentally engaged during patient consult created an increase in positive experiences. In reporting his experience with the surgeon, one study participant stated, “He came in every morning with one of his assistants and asked if we had any questions and spent as much time as we needed”.

Positive patient reactions consistently emerged when healthcare providers exhibited behaviors that created an impression of being emotionally aware and mentally engaged during the patient interaction. Reporting on her experience with healthcare providers during her entire care and recovery, one study participant jokingly responded, “If it wasn’t clear, it was my fault...because he was always asking is there anything else.”

Eight study participants reported attentiveness that exceeded their expectations and encouraged a feeling of partnership between themselves and the healthcare provider involved. Describing shared decision making during orthopedic care, one participant revealed that, “I don’t think there was ever a time that I didn’t feel like I had a say in what was going on”. The perception of attentiveness from healthcare providers had an overall major impact on the experiences of study participant’s undergoing orthopedic surgery. Another study participant’s response to a question regarding feeling if she had a say in decisions about her care reported the experience while working with rehabilitation staff after surgery “they were attentive enough that when I said no I’m not, I can’t do that right now...I mean they still pushed”.

A significant proportion of respondents (30%) reported lack of timeliness during in-patient postoperative care. While lack of timeliness did not always lead to an overall negative perception of the experience, in every case where lack of timeliness occurred, respondents were affected enough by it to make it a major theme in discussing their inpatient experience. Most frequently reported was lack of timely assistance with ambulation to the bathroom during in-patient postoperative care. For two participants this particular lack of timeliness, corresponding with interactions that lacked an impression of healthcare providers being emotionally aware and mentally engaged, had a defining negative effect on their overall experience.

While patient education about fall prevention is usually provided at the earliest opportunity, one study participant found the lack of timely response to requests for ambulation assistance so delayed, she removed the continuous progressive motion device attached to her knee and the two sequential compression devices on her feet in order to

walk to the bathroom. She reported “I wasn’t supposed to do that without help, but they wouldn’t show up and ... when I found I could do it myself then I would.” Another participant also indicated that slow response time led him to ambulate without assistance very early in the post-operative period, stating “I just assumed since I could get up and walk, I could get to the restroom and back by myself.” When the confidence was built the desire for independence superseded the understanding of the education given. Study participant’s reported experiences with orthopedic surgery was greatly influenced by the healthcare provider’s attentiveness and timely response to needs and questions.

Two study participant’s reported lack of attentiveness by describing how some healthcare providers encountered did not exhibit behaviors that created the impression of being emotionally aware and mentally engaged during care. One study participant described how a healthcare provider assisting her to ambulate gave her the perception that he was too busy to meet her expectations “He handled my knee quite roughly and I said hey that hurts.” A sense of the healthcare provider not being emotionally aware and mentally engaged had a significant enough impact that the interaction was mentioned a total of three times during the interview. Although this study participant reported her experience overall as positive stating, “They were fantastic” and “Now everybody in the hospital was super great”. The second study participant reflected on her experience, “They were treating the knee and not much of anything else”. She reported expectations of consideration for her whole life and special needs present due to her individual process.

A negative impression of healthcare provider attentiveness was reported when patients did not feel opportunities were created to participate in decisions regarding their

orthopedic surgical care. Addressing the difference in individual study participants' recovery due to preexisting factors was lacking for one study participant who reported "I'm thinking what is wrong with me? And ya know nobody...they just said it will get better".

Theme II: patient education.

In this study, the theme of patient education emerged in the form of comments addressing the essential nature of education and information sharing throughout the initial meeting before surgery, preoperative testing, perioperative period, postoperative inpatient stay, and rehabilitation through follow up. Thorough patient education was essential to positive outcomes reported by 100% of respondents in described experiences. Patient education in reported experiences created a feeling of being part of the decision making process and produced increased confidence in care delivered by healthcare providers.

Education and information given to study participants was reported at every stage; preoperative testing, perioperative, post-operative inpatient hospital stay, during the physical therapy rehabilitation and even at follow up visits with healthcare providers. This gave the study participants the feeling of being part of the decisions about care. Reflecting on his experience with the clarity of education one study participant stated "I never felt like I didn't know what was going on". He also reported receiving written materials to support verbal education given, stating "I had flyers and papers that told you what to expect". During experiences when study participant's reported no previous knowledge of a certain intervention it was described "They always explained what they were going to do before they did it", this type of patient education produced a confidence in provider care.

An experience that caused one study participant to comment on twice during the interview was how a healthcare provider delivered discharge education describing it as “quick” and this created the perception the information was incomplete, decreased confidence in care delivered and desire for independence. Another study participant reported “I got a bunch of paper” when discussing her discharge experience and felt the lack of thorough discussion about the discharge paper work established a more difficult post hospital recovery, decreasing desire for independence, and decreasing confidence in care. Even if the experience with patient education was negative, study participants reported “if I had only been told” or “if that had been a reported possibility”. The feeling of decreased confidence in healthcare provided resulted when patient education was lacking in 100% of negative experiences reported.

Fifty percent of study participant experiences reflected the advantage of having a previous orthopedic joint replacement surgery. Mainly the vantage point of “I probably knew what was going to happen before they did”. The knowledgeable study participant still reported desiring information and education stating, “They were really confident...explained everything and went through the x-rays”.

An interesting experience of one study participant during his recovery regarding patient education was a sense of “I didn’t know what to expect”. While at the same time reporting “they gave us good information up front”. This was a first total joint replacement surgery for the study participant and the unknown was more of a concern. This study participant was willing to adjust expectations as he recovered due to information and education provided. He stated “It was a different aching in the knee...I

guess I was expecting it was just going to be like a brand new knee...but I'm not 20 years old". Overall the experience was described as positive.

Theme III: patient need for control.

In this study, the theme patient need for control emerged in the form of comments addressing the experience of shared decision making or the perceived lack of decision making. When procedures, expectations, or processes were assumed in alignment with standard protocol without shared decision making or a sense of partnership then it created conflict highlighting the need for control.

Partnering with healthcare providers in decision making was noted to satisfy the need for control when physical therapy was discussed. One study participant described her experience with ambulating for the first time three hours post-surgery as "scary" and she was initially opposed to the activity, but after encouragement and education from healthcare providers she chose to proceed. This resulted in reported confidence and was encouraging to the study participant, set up a positive outlook towards discharge, and confidence in her functional ability.

Study participant experiences describing a desire for independence and discharge planning corresponded with the theme of need for control. One study participant explained how the consideration of individual needs formed a partnership when his discharge plan was adjusted. He stated, "it was my choice...he said I could go home tonight". The ability of his family help at home was improved by a third night stay in the hospital. The healthcare providers involved gave the study participant the impression that this was an established and understood partnership without any negative feelings.

One study participants' experience during interactions with healthcare providers during the entire preoperative, perioperative, post-operative, and rehabilitation recovery did not meet expectations. She reported observing multiple breaches in assumed care standards that brought her concern regarding competency of healthcare providers. She reported, "The surgery, I needed it. I had to have it. I wish I had better results. I know I expect things to be better right away because that's the way I am, but I've done well. I've done what I'm supposed to do. I really listened, and I just want more. I don't want to wait 18 months." The relationship between study participant and healthcare providers began to erode after expectations in recovery timeline were longer than what was discussed preoperatively. The responses given to the study participant seemed too generalized and did not reflect her goals and values. She expressed the slower recovery would have been more acceptable had the potential for the perceived delay been discussed preoperatively. It was also this study participant's experience that expected interaction with healthcare providers were lacking, "I thought they would pop in more to check on me." The study participants need for control was not met with enough education or shared decision making and since responses from healthcare providers did not meet expectations an overall negative experience was reported.

Theme IV: consideration of patient's whole life experience.

In this study, the theme consideration of patient's whole life experience emerged in the form of comments addressing the need for individualized care. Study participant's individual experiences with orthopedic surgical care was notably influenced by their whole life experience, subsequent adaptation, and resulting attitudes.

The responses of study participants consistently reflected positive statements when all aspects of their care was perceived to be aligned with established goals and values. The goals and values of the orthopedics surgical patients were dictated by the whole life experience leading to the surgery. The adaptation and attitudes of each orthopedic surgical patient was unique.

The consideration of the whole life experience caused one study participant to feel a partner in the decision making process. This study participant reported he had waited for many years prior to retiring knowing he needed the surgery. He stated, “I said I want them fixed and he said you’re in the right place”. Then, it was mutually decided upon to schedule his knee replacement surgeries approximately six weeks apart to aid in financial concerns and rehabilitation. Due to consistent consideration for his whole life experience he reported the encounters with healthcare provider’s overall as “excellent”.

For eight of the study participants the consideration for their whole life experience in recovery and rehabilitation planning was a positive yet shortly mentioned topic during the interview. A perception that it was an assumed standard practice to take into consideration the life experience of the individual study participants was observed. The healthcare provider’s consideration of the whole life experience is reflected by the positive outcomes. These experiences did not create conflict with the goals and values of the study participant’s.

One study participants experience illustrates the problems created by lack of consideration by healthcare providers for the patient’s whole life experience. This study participant was a full time caregiver for another family member, which meant that being absent from home created significant distress. Discharge from hospital to home was

requested, instead of the recommended stay in a rehabilitation facility due to a slower recovery progression. In discussing this with healthcare providers, it was indicated that there was an understanding this deviation from standard care would probably extend recovery time; but that the exigency of the family situation required it. Specifically, this change in schedule required deviation from standard postoperative care. Although the physician was reportedly agreeable to this request; nursing staff caring for the study participant was reluctant to the discharge planning ordered by the physician and initially resisted; causing a reported feeling of “animosity” during the remainder of the inpatient stay.

The whole life experience of a physically active study participant whose progression towards a total joint replacement resulted from an accident that was not in their control. The years of “putting off” the needed surgery because of other health concerns created a long health history. This study participant also had previous healthcare knowledge that established a set of expectations, reporting “I was always observing and I expected them to pop in more to see how I was doing.” The lack of perceived attention to the whole life experience created a negative experience for the study participant. The study participant reported “if they had just spent more time to really find out what you need.” The study participant had an extensive health history that created a need to not consume certain prescription medication due to an understood potential interaction, the experience was that this was not considered acutely enough and the concern was mentioned in two statements during the interview. While, the physical therapy rehabilitation experience was overall positive, stating “I actually felt better after I had therapy.” The lack of consideration of whole life experiences caused the feeling of

being “shorted” in the number of actual physical therapy visits. The study participant was having to reschedule therapy visits because of a care giving role for an immediate family member. The perception of the study participant was that the insurance would cover a great deal more therapy visits; while simultaneously being informed it was time to discharge from therapy after meeting necessary tested requirements. The experience magnified her overall feeling of lack of attentiveness and lack of consideration for her whole life experience.

Summary

The experiences reported by study participants and themes discovered during data content analysis: Healthcare provider attentiveness, patient education, patient need for control, and consideration of the patient’s whole life experiences have been detailed. The discovery of key features from the experiences of the patients’ themselves is important to establish areas for change to improve outcomes and confirm areas that are working well for patients. Next, a discussion of the themes will expand on the discoveries.

Chapter V

Discussion and Recommendations

Introduction

The primary purpose of this phenomenological qualitative study was to identify specific areas for improvement in the care of surgical orthopedic patients. To partner with adult patients to examine their experiences and perceptions of the benefits and challenges during the entirety of orthopedic surgical care. Planning and implementation of orthopedic surgical care is more effective when patients understand fully and take part in the process (U.S. Department of Health and Human Services, 2014). This chapter provides a discussion, implications, strengths, weaknesses, and recommendations for future research. Data collection was guided by three research questions:

1. What experiences during an orthopedic surgical patients' care provide insight to needed changes in practice?
2. What aspects of the orthopedic surgical patients' care experience was unclear or confusing?
3. What experiences made orthopedic surgical patients feel part of the decision making process in their partnership with healthcare providers?

The research questions gave an outline for the topic guided auto recorded interviews. Through the content analysis of data, insight was gained into the lived experience of the adult orthopedic surgical patient. After transcription, the interviews were analyzed to understand the experience as a whole, statement by statement for meaning units, formulating categories and then double checked word for word as the themes developed. This researcher constantly referred back to transcriptions to ensure accuracy of experience was reflected. Extracted from the experiences of orthopedic surgical patients, the themes reflect specific areas that affected individual care reported and speak to each of the three research questions. A discussion of the themes that emerged: Healthcare provider attentiveness, patient education, patient need for control and consideration for patient's whole life experience will follow.

Theme I: healthcare provider attentiveness.

In this study, the theme of healthcare provider attentiveness emerged in the form of comments addressing timely response to patient needs, healthcare providers exhibiting behaviors that create an impression of being emotionally aware and mentally engaged during patient consultation, and providers creating opportunities for the patient to participate in the decision-making process. Researchers Marshall, Kitson, & Zeitz discovered themes, while studying patients' views in one surgical unit, that patients' equated with patient-centered care; connectedness, involvement and attentiveness were reported (2012, para 4.). The experiences of study participants reflect the need for healthcare providers to meet expectations of adult orthopedic surgical patients. The impression from study participants was clear and understood, that it isn't enough to have a good reason not to meet expectations; a busy hospital or office was never an accepted

excuse when expectations were not met. For example, timely response to needs of toileting, need to anticipate time of day for discharge not just the possible day, continually planning individualized care, and updating the patients where all areas that were specifically reported to be important to study participant's.

Giving the impression of being emotionally aware and mentally engaged was important to the study participant's perception of healthcare provider attentiveness. Increasing the patients understanding of procedures was an excellent and common step towards an effective partnership with healthcare providers. Giving patients examples and descriptions of processes; for example, showing the orthopedic surgical patient their x-ray, labs, probable orthopedic implant before and during care increased understanding and fostered everything about healthcare provider attentiveness. This combines educating and informing the patient at the same time; "showing" the patient healthcare providers are doing their job, enables them to be attentive and informative without added feeling of effort.

Patients often associate care with the people who deliver the care (Marshall, Kitson, & Zeitz, 2012). This magnifies the important of healthcare provider attentiveness. Even if the care provided was adequate; if the perceived attentiveness did not meet expectations the outcome is considered more negative.

Theme II: patient education.

The theme of patient education was discovered as study participants described having adequate or inadequate information provided. To ensure patients are not negatively affected by any change in orthopedic surgical procedures and techniques healthcare providers must educate continually. Researchers Tung et al. (2012) found that

education from healthcare providers relating to adaptive strategies and goal setting was important: The discovery of one theme “Nurturing self-efficacy through working with others” speaks to the partnership creating confidence (p. 1220).

Topic guided questions asking if information was clear or unclear produced responses that consistently highlighted the importance of clarity patient education. Shorter hospital stays require more focused education to ensure confidence in functional ability at discharge. Noting that there is often a reduced level of confidence and motivation in patients following discharge from orthopedic surgery (Tung et al., 2012).

During this study an unexpected element of patient education was the advantage of prior knowledge of procedure and recovery process. This always positively influenced the orthopedic surgical experience due to enough education and knowledge of what to expect. The confidence that these study participants modeled appeared to be consistent 100% of the time. When considering the advantage of knowing what to expect provided the study participants; it would be effective patient education to attempt to create a similar level of education for everyone. Possibly supplying each orthopedic surgical patient with a printed schedule of the potential day to day plan of progress and a few comments regarding what to expect. This plan of process could be tailored for each orthopedic surgical patient. This type of patient education allows for accountability of actions between healthcare providers and patients; and supports the partnership. Of the experiences reported in this study, none of the participants ever mentioned having too much information or that the education was unnecessary.

Theme III: patient need for control.

In this study the patient need for control is a clear request for information and partnership. The feeling of resistance to many processes can be alleviated by information sharing; coming to an understanding that incorporates the values and goals of all involved. Researchers Legare et al., (2012) systematic review states, “Patients’ participation in decision making is associated with better health outcomes and with greater satisfaction with the consultation process” (p. 2).

An obstacle to partnership is healthcare providers that see patient research and patient need for control as a conflict. Researchers Holzel, Kriston, and Harter tested a hypothesis of patient participation and willingness to take responsibility in the care decision making process; results were clear that “...higher patient involvement clearly lowered decisional conflict” (2013, p.5). Healthcare providers must view a patients’ need for control as a strength that encourages ownership of care and builds the patient-healthcare provider partnership.

Theme IV: consideration of patient’s whole life experience.

Theme four requires attentiveness, understanding and consideration of the whole life experience, which effects how a study participant will respond to treatment. Researchers Gustafsson, Ponzer, Heikkila, and Ekman (2007), reported on the experiences of patient perioperative period in knee and hip replacement surgery, “A life with a gradually-deteriorating body usually included many different types of treatment over a period of several years before being listed for surgery” (p.4, para. 2). Considering the adult surgical patients entire medical and social history describes the challenges encountered and strengths developed during their life experience. When healthcare providers consider the value of partnering with patients to understand their goals and

values the whole life experience can be revealed. Healthcare providers delivering care must continually identify areas for care improvement and utilizing the patients experience and values is an important factor (Delbanco & Gerteis, 2013).

Study participants would report how the majority of experiences were positive; yet it would only take one negative experience to alter their entire perception of the interactions. In other cases, study participants would discuss negative experiences with more frequency during the interview while still reporting an overall positive experience. An understanding that everything can be wonderful but it only takes one negative aspect to skew patients' perception is important to propel healthcare providers towards consistency and excellence in care.

Considering the patients' whole life experience is the identification of the adaptive qualities that have resulted from previous experience. By quickly acknowledging care management that did not work for a patient previously; allows for fears and apprehensions to be expressed, along with a greater understanding of expectations, and more individualized approaches to meeting them. This information could be easily collected on intake paperwork as part of the initial screening.

The Researchers Delbanco and Gerteis (2013) found that what patients' value may differ from what healthcare providers may recommend and stated "Shared decision-making approaches can help clinician and patient, together, clarify options, outcomes, uncertainties, and values" (para 6). If healthcare providers could take the patients whole life experience and use the information for increased shared decision-making, goal setting, and a true sense of individualized care; patients' experiences with orthopedic surgical care would be reported as consistently positive.

Other Considerations

Derived from responses, the feeling that all expectations will be met was assumed by all study participants in this research. Importance of meeting expectations is essential, but healthcare providers must first know what they are. For example, the need to anticipate time of day for discharge was described by one study participant. Simply asking the patients “what are your expectations” followed by “here is a list of my expectations” would allow for clarity in care.

Ensuring healthcare providers evaluate prejudice and personal values present in their own existence allows for greater clarity in communication with patients. The essential skill of communication was an understood theme throughout this research. As described in the literature review, emphasis on communication is a common theme in all aspects of care delivery. Researchers Wye, Shaw, and Sharp (2009) reported how professionals need to reduce the power of influence that they carry and acknowledge the legitimacy of patient preferences. Skill in communication can be described using the themes this study discovered: Healthcare provider attentiveness, patient education, patient need for control and consideration for patient whole life experience. Being attentive, understanding the patients’ whole life experience and need for control while sharing information describes communicating effectively.

Conservation Model

The theoretical framework of Myra Estrin Levine and Levine’s Conservation Model guided this research. The major concepts of Levin’s conservation model are wholeness, adaptation, and conservation (Alligood, 2014). While reflecting on their experiences during orthopedic surgery the study participants were able to report when

interactions and interventions promoted adaptation and wholeness. This ability to adapt by orthopedic patients is referred to as the organismic response. Included in the organismic response is the ability to convert the experience into a meaningful one (Alligood, 2014). The healthcare provider- patient partnership was understood to be essential in the conservation of energy and personal integrity in this research. When study participants' care corresponded with their beliefs and values, there was not an extra expenditure of energy, wholeness was maintained, as adaptation to a new life with total joint arthroplasty occurred.

Implications for Nursing

Healthcare providers need to understand orthopedic surgical care from the perspective of the patient experience. The aspects of care delivery that patients' find effective and less effective must guide practice. This individualized care, along with evidenced based practice, will consistently produce positive patient outcomes. Just as individuals make choices everyday based on past experience, previous influences, and resulting attitudes: Adult orthopedic surgical patients require care that considers these same aspects. A successful surgery from the perspective of the patient does not only include infection prevention, lack of falls, and functioning joint replacement; it is inclusive of the entire experience. Healthcare providers caring for adult orthopedic surgical patients need not solve all problems facing them, but consideration of all aspects of patients' experiences will give the impression of being attentive, emotionally aware, and mentally engaged.

Patient whole life experience is essential to care planning and understanding goals and values. Education and information sharing is a constant to effective care reported by

the study participant's. The patients need for control is appropriate and can be useful in encouraging independence and recovery that coincides with stated goals and values. This must be considered with each individual patient to ensure care is specific and outcomes are consistently positive.

Strengths and Limitations of Study

The cooperation of study participant's and willingness to report individual experiences was a strength. The setting of all audio recorded interviews was selected by the study participant creating a more comfortable and private atmosphere; allowing for increased sharing of experiences.

The number of study participant's (10) whom agreed to participate verses the size of the population recruited from (150) was a limitation. Although the number of study participant's is adequate for qualitative research, the probability of all experiences being reflected by the 10 study participants accounting for all orthopedic patient's experiences is not likely. The study cannot be generalized to all patient populations.

Recommendations for Future Research

The adult orthopedic surgical patient experience can and should be consistently recorded and analyzed for areas of needed improvement in care. The researcher for individual orthopedic surgeons or hospitals could discover within populations directly served the best adjustments to interactions and interventions, ensuring they promote adaptation and maintain wholeness, working towards improved outcomes.

More research developing and implementing patient education during preoperative, perioperative and postoperative care that encourages healthcare provider – patient partnerships, leading to shared decisions that meet the patients need for control.

The researcher could look at implementing ending statements by healthcare providers that include the feeling of giving the patient a choice at all interactions. Patient choice is fundamental, but patient experience with feeling as though they have a choice is not always present. Patient choice is greatly influenced by education materials provided. The researcher could look at patient education in written format and adjust for more effectiveness. The researcher could implement a written day to day plan of care individualized to each orthopedic surgical patient, with provided education, and tracking protocols.

Research needs to be done on how to implement education for healthcare providers that emphasizes the consideration of patient whole life experience. The researcher could look into ways healthcare providers could view and tabulate previous life experience in a meaningful way. Possibly on intake paperwork, with the patient simply listing previous issues with surgeries or experiences that were effective for them. The challenge would be to see how the patient whole life experience can be reflected upon quick enough so a time conflict would not be created.

Conclusion

With over one million total knee and hip joint arthroplasty surgeries performed across America yearly, care of adult patients must continually be evaluated to ensure effectiveness (CDC, 2015). The experiences of adult orthopedic surgical patients have revealed areas of effective care and areas that require improvement. The attentiveness of healthcare providers created responses by study participant's that described the essential nature of timely response to patient needs, healthcare providers exhibiting behaviors that create an impression of being emotionally aware and mentally engaged during patient

consultation, and providers creating opportunities for patients to participate in the decision-making process. The importance of education and understanding the patients need for control leading to effective partnerships with healthcare providers is identified. This research also discovered the need for patients to be cared for as individuals with consideration for their whole life experience during the entirety of orthopedic surgical care. The qualitative, phenomenological approach allowed specific description of areas adult orthopedic surgical patients found important to the care delivered.

References

- Alligood, M. R. (2014). *Nursing theorists and their work* (8th ed.). St. Louis, MO: Elsevier.
- Bhattacharyya, T., Freiberg, A. A., Mehta, P., Katz, J. N., & Ferris, T. (2009). Measuring the report card: The validity of pay-for-performance metrics in orthopedic surgery. *Health Affairs*, 28, 526-532. <http://dx.doi.org/10.1377/hlthaff.28.2.526>
- Boykins, A. (2014). Core communication competencies in patient-centered care. *Association of Black Nursing Faculty*, 40-47. Retrieved from www.tuckerpub.com
- Centers for Disease Control and Prevention, (CDC). (2015). National Center for Health Statistics: Inpatient Surgery. Retrieved from <http://www.cdc.gov/nchs/fastats/inpatient-surgery.htm>
- Chetty, C., & Ehlers, V. (2009). Orthopaedic patients' perceptions about their pre-operative information. *Curationis*, 32(4), 55-60.
- Delbanco, T., & Gerteis, M. (2013). A patient centered view of the clinician-patient relationship. Retrieved from http://library.pittstate.edu:2921/contents/a-patient-centered-view-of-the-clinician-patient-relationship?source=search_result&search=communication&selectedTitle=1~150
- Ferreira, P. H., Ferreira, M. L., Maher, C. G., Refshauge, K. M., Latimer, J., & Adams, R. D. (2013). The therapeutic alliance between clinicians and patients predicts outcome in chronic low back pain. *Physical Therapy Journal*, 93(4), 470-478. Retrieved from <http://ptjournal.apta.org/>

- Flierler, W. J., Nubling, M., Kasper, J., & Heidegger, T. (2013). Implementation of shared decision making in anaesthesia and its influence on patient satisfaction. *Anaesthesia 2013 The Association of Anaesthetists of Great Britain and Ireland*, 68, 713-722. <http://dx.doi.org/10.1111/anae.12196>
- Foisy, K. (2013). Thou shalt not fall! Decreasing falls in the postoperative orthopedic patient with a femoral nerve block. *MEDSURG Nursing*, 22(4), 246-250. Retrieved from <http://www.medsurnursing.net/cgi-bin/WebObjects/MSNJournal.woa>
- Gustafsson, B., Ponzer, S., Heikkila, K., & Ekman, S. (2007, June 15). The lived body and the perioperative period in replacement surgery: older people's experiences. *Journal of Advanced Nursing*, 60(1), 20-28. <http://dx.doi.org/10.0000/j.1365-2648.2007.04372.x>
- Heikkinen, K., Salantera, S., Leppanen, T., Vahlberg, T., & Leino-Kipi, H. (2012). Ambulatory orthopaedic surgery patients' emotions when using two different patient education methods. *Journal of Perioperative Practice*, 22(7), 226-231. Retrieved from www.aorn.com/AORNJournal
- Holzel, L., Kriston, L., & Harter, M. (2013). Patient preference for involvement, experienced involvement, decisional conflict, and satisfaction with physician: a structural equation model test. *BMC Health Services Research*, 13(231), 1-10. Retrieved from <http://www.biomedcentral.com/1472-6963/13/231>
- Hunt, E., Moore, J., & Sherriff, J. (2012). Community health-care planning in Western Australian Country Health Service-South West an evaluation of patient views.

Nutrition & Dietetics, 69, 26-31. <http://dx.doi.org/10.1111/j.1747-0080.2011.01571.x>

Institute of Medicine of the National Academies. (2011). *The Future of nursing: Leading change, advancing health*. Retrieved from <http://www.nap.edu>

Kansas Health Care. (2014). <http://hcsf.kansas.gov>

Legare, F., Turcotte, S., Stacey, D., Ratte, S., Kryworuchko, J., & Graham, I. D. (2012). Patients' perceptions of sharing in decisions A systematic review of interventions to enhance shared decision making in routine clinical practice. *Adis Data Information BV*, 5(1), 1-20. <http://dx.doi.org/10.2165/11592180-000000000-00000>

Legendra, Y. R., & Witzkin, E. J. (2014, April). Recommendations from the Macy Foundation Conference on Partnering with Patients, Families, and Communities to Link Interprofessional Practice and Education. , 1-16. Retrieved from www.macyfoundation.org

MacPherson, A., Walshe, C., O'Donnell, V., & Vyas, A. (2012). The views of patients with severe chronic obstructive pulmonary disease on advance care planning: A qualitative study. *Palliative Medicine*, 27(3), 265-272. <http://dx.doi.org/10.1177/0269216312440606>

Marshall, A., Kitson, A., & Zeitz, K. (2012, February 4). Patients' view of patient-centered care: a phenomenological case study in one surgical unit. *Journal of Advanced Nursing*, 68(12), 2664-2673. <http://dx.doi.org/10.1111/j.1365-2648.2012.05965.x>

Merriam-Webster. (2014). <http://www.merriam-webster.com/dictionary>

- Mettler, E. A., Preston, H. R., Jenkins, S. M., Lackore, K. A., Werneburg, B. L., Larson, B. G., ... Clark, M. M. (2014). Motivational improvements for health behavior change from wellness coaching. *American Journal of Health Behavior*, 38(1), 83-91. <http://dx.doi.org/10.5993/AJHB.38.1.9>
- National Patient Safety Foundation*. (2008). National agenda for action: Patients and families in patient safety nothing about me, without me. National Patient Safety Foundation, 1-12. Retrieved from www.npsf.org
- Norgaard, B., Kofoed, P. E., Kyvik, K. O., & Ammentrop, J. (2012). Communication skills training for health care professionals improves the adult orthopaedic patient's experience of quality of care. *Scandinavian Journal of Caring Sciences*, 26, 698-704. <http://dx.doi.org/10.1111/j.1471-6712.2012.00982.x>
- Orr, M., & Plaut, D. (2014). Complex systems and health behavior change Insights from cognitive science. *American Journal of Health Behavior*, 38(3), 404-413. <http://dx.doi.org/10.5993/AJHB.38.3.9>
- Perry, M. A., Hudson, H. S., Meys, S., Norrie, O., Ralph, T., & Warner, S. (2012). Older adults' experiences regarding discharge from hospital following orthopaedic intervention: A metasynthesis. *Disability & Rehabilitation*, 34(4), 267-278. <http://dx.doi.org/10.3109/09638288.2011.603016>
- Polit, D., & Beck, C. (2012). *Nursing research Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Poochikian-Sarkissian, S., Sidani, S., Fergusin-Pare, M., & Doran, D. (2010). Examining the relationship between patient-centered care and outcomes. *Canadian Journal of Neuroscience Nursing*, 32(4), 14-22. Retrieved from www.cann.ca

- Shaw, M., Richards, T., Wood, S., & Calvert, E. (2014). Streamlining orthopaedic nursing. *Kai Tiaki Nursing New Zealand*, 20(6), 23-26. Retrieved from www.nzno.org.nz
- Slatore, C., Hansen, L., Ganzini, L., Press, N., Osborne, M., Chesnutt, M., & Mularski, R. (2012). Communication by nurses in the intensive care unit Qualitative analysis of domains of patient centered-care. *AMERICAN JOURNAL OF CRITICAL CARE*, 21(6), 410-418. <http://dx.doi.org/10.4037/ajcc2012124>
- Slover, J., Shue, J., & Koenig, K. (2012). Shared decision-making in orthopaedic surgery. *Clinical Orthopaedics and Related Research*, 470, 1046-1053. <http://dx.doi.org/10.1007/s11999-011-2156-8>
- Suhonen, R., Papastavrou, E., Efstathiou, G., Lemonida, C., Kalafati, M., Antunes da Luz, M., & Kilpi, H. (2011). Nurses' perceptions of individualized care: an international comparison. *Journal of Advanced Nursing*, 67(9), 1895-1907. <http://dx.doi.org/10.1111/j.1365-2648.2011.05626.x>
- Tung, Y., Cooke, M., & Moyle, W. (2012). Sources older people draw on to nurture, strengthen and improve self-efficacy in managing home rehabilitation following orthopaedic surgery. *Journal of Clinical Nursing*, 22, 1217-1225. <http://dx.doi.org/10.1111/j.1365-2702.2012.04252.x>
- U.S. Department of Health and Human Services. (2014). Healthy People 2020 Health Communication and Health Information Technology. Retrieved from <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=18>

- Unbeck, M., Dalen, N., Muren, O., Lillkrona, U., & Harenstam, K. (2010). Healthcare processes must be improved to reduce the occurrence of orthopaedic adverse events. *Scandinavian Journal of Caring Sciences*, *24*, 671-677.
<http://dx.doi.org/10.1111/j.1471-6712.2009.00760.x>
- Williams-Piehot, P. A., Sirois, F. M., Bann, C. M., Isenberg, K. B., & Walsh, E. G. (2011). Agents of change: How do complementary and alternative medicine providers play a role in health behavior change? *Alternative Therapies in Health and Medicine*, *17*(1), 22-32. Retrieved from <http://www.alternative-therapies.com>
- Wong, E., Chan, S., & Chain, S. (2009). Effectiveness of an educational intervention on levels of pain, anxiety and self-efficacy for patients with musculoskeletal trauma. *Journal of Advanced Nursing*, *66*(5), 1120-1131. <http://dx.doi.org/10.1111/j.1365-2648.2010.05273.x>
- Wye, L., Shaw, A., & Sharp, D. (2009). Patient choice and evidence based decisions the case of complementary therapies. *Health Expectations*, *12*(3), 321-330.
<http://dx.doi.org/10.1111/j.1369-7625.2009.00542.x>

APPENDIX

APPENDIX A

Interview Topic Guide with Field Notes

Archival code:

Site:

Interviewer: Sacha DeGraffenreid-Yates

Date: Start Time: End Time:

Transcriber:

Date Transcribed:

Do you consent freely to participate in this tape recorded interview?

Do you understand you may withdraw from this interview and study at any time without
prejudice?

Demographic data

Age category: (50-59) (60-69) (70-80) Surgery received: THA TKA

Gender: Date of Surgery received:

Research Question 1. What experiences during an orthopedic surgical patient's care
provide insight to needed changes in practice?

- a) Think back before surgery what things about your care would you have changed?
- b) What experience makes you say this?
- c) How about during surgery what would you have changed?
- d) What experience makes you say that?
- e) When you came out from surgery during your hospital stay and rehabilitation period, was there anything you would have changed?

f) What experience makes you say that?

Research Question 2. What aspects of the orthopedic surgical patients' care experience was unclear or confusing?

a) Describe any experience at any point during your care that was unclear?

b) Think back are there any questions you wish you would have asked during your care?

c) What happened during your care that was confusing to you?

d) What experience makes you say that?

Research Question 3. What experiences made orthopedic surgical patients feel part of the decision making process in their partnership with healthcare providers?

a) Think about your experiences making decisions before surgery. Can you give me examples of ways you felt your opinions and decisions were honored by the healthcare providers caring for you?

b) Think about your experiences making decisions the day of surgery. Can you give me examples of ways you felt your opinions and decisions were honored by the healthcare providers caring for you?

c) Think about your experiences making decisions after surgery and during rehabilitation. Can you give me examples of ways you felt your opinions and decisions were honored by the healthcare providers caring for you?

In conclusion, this is what I understand of your experiences from throughout the interview. Is there anything that is incorrect in my understanding?

Thank you for your time and participation in this research.

APPENDIX B

Letter of Invitation

Dear Participant:

You are invited to participate in a phenomenological qualitative research study involving an interview regarding your individual orthopedic surgical care experiences. Participation includes an interview that will take approximately 30 minutes - 1 hour to complete. Location and time of interview would be at your convenience. Participants will be asked questions about their experiences with orthopedic surgical care. Participants will be asked to give feedback prior to conclusion of the interview to ascertain whether the researcher has accurately noted the experiences, perceptions, and ideas of the participant. Participants may leave after conclusion of interview.

Participation in this study is completely voluntary with no specific benefits or risks in participating identified. The primary purpose of this phenomenological qualitative study is to identify specific areas for improvement in the care of surgical orthopedic patients. To partner with adult patients to understand their individual experiences related to orthopedic surgical care. Archival code will be used on all transcripts for confidentiality purposes. You may withdraw from the study at any point without fear of prejudice or reprisal.

This research is being conducted by Sacha DeGraffenreid-Yates, RN, BSN, FNP-Student Pittsburg State University and Jennifer Harris, PhD, FNP-C, APRN the principal investigators at Pittsburg State University, Irene Ransom Bradley School of Nursing. Further information will be provided as requested, please contact Sacha DeGraffenreid-Yates at sdegraffenreid-yates@gus.pittstate.edu or at (417)825-1430.

If you are willing to participate in the study, please call at any time or wait for a follow up call within one week. There will be implied consent when the interview is scheduled and written consent at the time of the interview.

Thank you for assisting in this research study. Your time and responses are truly appreciated.

Sincerely,

Sacha L. DeGraffenreid-Yates, RN, BSN, FNP-Student Pittsburg State University

APPENDIX C

PITTSBURG STATE UNIVERSITY INFORMED CONSENT FOR RESEARCH

PROJECT TITLE: Partnering to improve patient outcomes: A qualitative study of adult patient experiences with orthopedic surgical care

APPROVAL DATE OF PROJECT:

November 2014

EXPIRATION DATE OF PROJECT:

May 2015

PRINCIPAL INVESTIGATOR:

Sacha DeGraffenreid-Yates, RN, BSN
Jennifer Harris, PhD, FNP-C, APRN

CONTACT AND PHONE FOR ANY PROBLEMS/QUESTIONS:

Sacha DeGraffenreid-Yates (417)825-1430

IRB CHAIR CONTACT/PHONE INFORMATION:

Cheryl Giefer, PhD, APRN 620-235-4431

Peggy Snyder, chair, Committee for the Protection of Human Research Subjects, 112 Russ Hall, Pittsburg State University, Pittsburg, KS 66762-7526, (602)235-4179.

PURPOSE OF THE RESEARCH:

The primary purpose of this phenomenological qualitative study is to identify specific areas for improvement in the care of surgical orthopedic patients. To partner with adult patients to understand their individual experiences related to orthopedic surgical care. Adult patients receiving orthopedic surgical care have experiences that can provide insight to needed improvements.

PROCEDURES OR METHODS TO BE USED:

If you agree to participate in this study, your participation will last approximately one hour. Your participation will involve...

- Topic guided interview.
- The interview will be audio recorded and transcribed by the student researcher.
- Your identity will be kept confidential by using an archival code as the identity marker for your transcribed interview comments and will only be known to the researcher.
- All recordings will be destroyed after analysis of the data is completed.
- The transcriptions of recordings from each interview will be maintained in a secured file at the Pittsburg State University Irene Ransom Bradley School of

Nursing as required by the research review board for 6 months and then destroyed.

ALTERNATIVES:

Participation in this study is voluntary.

LENGTH OF STUDY:

Study participants will be expected to participate for the 30 minute-1hour long interview.

RISKS ANTICIPATED:

No known risks or discomforts are anticipated from this research study.

BENEFITS ANTICIPATED:

No known benefits are anticipated from this research to the participant or researcher.

EXTENT OF CONFIDENTIALITY:

The researchers will protect your information as required by law. Your name will not be associated in any way with the information collected about you or with the research findings from this study. The researcher will use a study archival code (TR001-TR030) instead of your name. Transcriptions will be shared with the thesis chair via Pittsburg State University secure file transfer system. The researchers will not share information about you with anyone not specified above unless required by law or unless you give written permission.

TERMS OF PARTICIPATION: I understand this project is research, and that my participation is completely voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation, penalty, or loss of benefits or academic standing to which I may otherwise be entitled.

I verify that my signature below indicates that I have read and understand this consent form, and willingly agree to participate in this study under the terms described, and that my signature acknowledges that I have received a signed and dated copy of this consent form.

(Remember that it is a requirement for the Primary Investigator to maintain a signed and dated copy of the same consent form signed and kept by the subject.)

Participant Name: _____

Participant Signature: _____

Date: _____

Witness to Signature: (Project Staff) _____

Date: _____