AMBULATORY SURGERY POST-OPERATIVE LEARNING NEEDS:
A COMPARISON OF PATIENTS' AND NURSES' PERCEPTIONS

by

Martha F. D. Lisicki

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Martha F. D. Lisicki

Approved by:

Ruth M. Patterson 4-23-98
Chair, Thesis Committee Date

Member, Thesis Committee Date

Janis P. Bellana 7/1/98
Member, Thesis Committee Date

Interim Dean, College of Health Professions 7/1/98
Date
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Abstract

Martha F. D. Lisicki. Ambulatory surgery discharge learning needs: A comparison of patients' and nurses' perceptions. (Under the direction of RUTH M. PATTERSON, EdD.)

This study compared patients' and nurses' perceptions of post-operative learning needs in an ambulatory surgery setting. A 40-item questionnaire, designed to measure discharge learning needs, was collected from outpatient gynecological surgery patients (n=42) and ambulatory surgery nurses (n=29) responsible for patients' discharge teaching. The survey included: (a) demographic data, (b) a 40-item Likert scale and, (c) a section asking respondents to choose the 5 most important items. Comparison by ranking and t-tests revealed differing perceptions between patients and nurses. Patients ranked "Complications and Symptoms" the most important category; nurses ranked "Medications" first. A significant difference existed in the "Medication" category. Nurses ranked 78% of the items higher than patients. Both groups identified "How to recognize a complication" as the most important. This study calls for an examination of present discharge teaching methods.
CHAPTER I

Background and Need

Patients, as consumers, are having a greater impact on the delivery of health care today than in previous decades. Their demands for health education, two-way communication, and active participation in health care decisions have pushed the health care industry to reevaluate many of its traditional practice norms. The scope of the nursing profession has also broadened, especially in light of the Pew Health Professions Commission's report on the seventeen competencies needed by health professionals by 2005. In its first report, Healthy America: Practitioners for 2005 (Shugars, O'Neil, & Bader, 1991), the Commission identified health education as one of the 17 competencies needed by health professionals in future health care delivery. One of the competencies, "involve patients and families in the decision-making process," (p. 19) expects health professionals to help patients and their families take a more active role in decisions about their health care. The Commission recognized consumer empowerment as one element that will shape the nation's health care delivery system.
More than ever, patients' health care decisions will be based on their perceptions of quality, cost, and convenience of health care (Shugars et al., 1991).

The importance of patient education first gained national attention in 1972 when the American Hospital Association published the Patient’s Bill of Rights. This policy established a framework to protect the rights of patients in determining their treatment options. It promotes a collaborative relationship between patients and health care professionals in making health care decisions. The Patient’s Bill of Rights encourages communication and allows patients the authority to make their own health care decisions based on consultation with the health care provider.

Today, the standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO, 1997) have a recurring theme of patient/family education. The education standard goal is "to improve patient health outcomes by involving the patient in care and care decisions" (p. 111). The American Nurses Association's Nursing's Social Policy Statement (1995) provides a list of "phenomena of concern" that include care and self-care processes, decision-and choice-making abilities, and the preference of patients, that serve as a guide in the
formulation of nursing plans of care. At the state level, the 1997 South Carolina Nurses Association's mission statement notes that the consumer's involvement in health care places more demands on nurses to provide patient education.

Growth in medical science this century has compelled the American public to become more involved in all aspects of their health care, including education. To meet these demands, health care facilities are forced to review their present education standards. Thus, more responsibility and accountability for patient teaching has been delegated to the nursing profession (Yura-Petro & Scanelli, 1992a, 1992b).

As health care shifts away from an illness model to a health and wellness model (Heinzer, McGoldrick, & McLane, 1996), it is accompanied by the transition of patients away from traditional inpatient to the outpatient setting. This holds true for outpatient surgery. Advanced surgical techniques and improved anesthesia agents allow healthy patients to recover at home post-operatively instead of being admitted to the hospital for an overnight stay (Anders, 1994).

The rapid growth of ambulatory surgery over the past several decades is an indicator of the impact managed care
has had on health care delivery. In a 1990 American Hospital Association survey, 84% of the hospitals surveyed provided outpatient surgery services. In contrast, the "outpatient surgery services" category was not listed in the 1980 survey. The number of surgeries performed in an outpatient surgery center increased from 3.2 million in 1980 to nearly 12 million in 1991 (Fraser, Lane, Linne, & Jones, 1993). Michel and Myrick (1990) estimated that approximately 70% of all surgeries would be performed in same day surgery facilities by the year 2000. They further suggest that success in these facilities depends upon consumers who are satisfied with the quality of care received and their perceived clinical outcomes. Studies have identified consumer satisfaction as one of the most efficacious measures of quality care (Hall, Roter, and Katz, 1988; Ludwig-Beymer et al., 1993; Zapka et al., 1995).

The evolution of ambulatory surgery centers has created a cultural change. The concept of patient empowerment is replacing traditional paternalistic health care. More than ever, achievement of desired patient outcomes is dependent upon the nurse accurately identifying patients' learning needs and providing the means to achieve the desired outcomes (Otte, 1996). Families assume
the role of principal caregiver when the patient is discharged home post-operatively. The ambulatory surgery nurse must discern the information and skills needed by both patient and family.

Time constraints imposed by outpatient surgery challenges the nurse to streamline the plan of care and provide in-depth patient education within a brief time span, thus requiring the nurse to be a master of technical, communication, and teaching skills (Cruz, 1990). This is especially true when the nurse may only spend a few hours with the patient between admission and discharge in contrast to longer stays of inpatients. Therefore, patient education standards for the ambulatory patient should be developed based upon their unique needs instead of adapting standards designed for inpatients (Michel & Myrick, 1990).

Development of outpatient teaching standards obligates the nurse to examine both the content and teaching methods used in patient education. Content based exclusively on inpatient standards will not provide outpatients with the information they need as the patient/family assumes the care that traditionally was provided by the nurse. To provide instructions relevant to the home care environment the nurse must first develop an understanding of what patients experience in the home environment. The patient
who has experienced outpatient surgery may now be the expert in determining post-discharge needs, with the nurse being the learner. The patient assumes the role of both patient and teacher as questions arise away from the surgery setting.

Nursing and educational theories assert that assessment of learning needs should provide the basis for all teaching activities. Evaluation of learning outcomes begins with the assessment phase. Motivation to learn is enhanced when teachers are able to incorporate their expertise of what patients need to know with the learners' expression of their perceived needs (Wlodkowski, 1993). In patient education, the needs assessment establishes the degree of congruence between the nurse's and patient's perceptions of these needs. The needs assessment provides a foundation for designing patient education activities. Identification of specific patient needs allows the nurse maximum time to address those needs. When there is congruence between the goals of the nurse and the needs of the patient, compliance usually increases (Redman, 1993).

Research has identified how, when, and why patient teaching is important (Meleis, 1997; Redman, 1993; Yura & Walsh, 1988). Teaching in the ambulatory setting must be based upon patient care needs in the home environment, not
the hospital. Identification of the most significant aspects of learning for the ambulatory patient is the first step in creation of an outpatient teaching plan. The literature is scant in the area of ambulatory patients' perceptions of their informational needs. It is incumbent on nurses to address the issue of patient learning needs in the ambulatory surgical setting given the ever increasing numbers of ambulatory patient encounters.

Purpose

The purpose of this study was to assess aspects of post-operative care perceived as important, by both nurses and patients, in the ambulatory surgery setting. The information collected provides information essential to the teaching process with emphasis on the needs assessment.

Research Questions

This study examined ambulatory patients' learning needs. Before standards of teaching can be developed it is imperative to begin at the beginning. Therefore, this study was designed to focus on the needs' assessment phase of outpatient teaching and tested the following questions:

1. What are nurses' perceptions of ambulatory surgical patients' postoperative educational needs?
2. What are ambulatory surgical patients' perceptions of their postoperative educational needs?

3. Is there a difference between nurses' perceptions and patients' perceptions of the ambulatory surgical patient's postoperative educational needs?

Population

The population of interest was adult gynecological patients admitted to, and discharged from, a hospital based ambulatory surgery facility the day of surgery and the registered nurses that participated in their post-operative education. It did not include patients admitted to the hospital for an overnight stay.

Operational Definitions of Terms

Ambulatory surgical patient (outpatient):

- a patient admitted to the hospital the day of surgery and discharged that day (Takahashi & Bever, 1989).

Inpatient:

- a patient who has been admitted at least overnight to a hospital or other health facility (Freudenheim, 1996).

Patient education:

- a planned learning experience using a combination of methods such as teaching, counseling, and behavior modification techniques that influence
patients' knowledge and health behavior
(Bartlett, 1985).

Postoperative:

time period beginning with the admission of the
patient to the post-anesthesia care unit and ending
with a resolution of surgical sequelae (Takahashi &
Bever, 1989).

Assumptions

It was assumed that the participants would (a) provide
candid responses, (b) be able to read and write English,
(c) be capable of interpreting and following the discharge
instructions accurately, and (d) return the survey within
the designated time.

Limitations

The study sample was limited to adult patients
admitted to, and discharged from, an ambulatory surgery
center for gynecological surgery. Data was collected for a
three month period at two hospitals. The results of this
study cannot be generalized beyond the sample population.
The effects of previous surgery or the effects of amnesiac
pharmacological agents on postoperative memory also may
affect the results of the study.

Institutional Review Board Review

Institutional Review Board approval was obtained
from both of the participating hospital sites. A copy of the approval form is on file at each hospital. Authorization for the study received exempt status.

Summary

Development of teaching standards will continue to be based upon the expertise and knowledge of the professional nurse, however regard for the patient's concerns must be considered. Evaluation of present teaching standards within the ambulatory care setting must begin by examining which information nurses and patients view as most important for patients' recovery from the surgical experience. Otte (1996) suggested that future teaching standards should be designed to meet the needs of the patient and not purely the needs of the professional. Teaching based upon patient needs allows the nurse more time to focus on the issues and concerns deemed important by the patient. Meeting the perceived learning needs of ambulatory surgical patients should enhance patient satisfaction and clinical outcomes.
CHAPTER II

REVIEW OF THE LITERATURE

As nursing searches for innovative ways to provide patient education in today's rapid pace healthcare system, it may be time to reexamine the importance of needs assessment in patient teaching. Despite universal recognition of the importance of assessment as the first step in both nursing process and teaching process models (Meleis, 1997; Redman, 1993; Wilkinson, 1996; Yura & Walsh, 1988), few articles address the patient's input in identifying informational needs. Before nurses can develop teaching plans designed to assist ambulatory surgical patients in caring for themselves at home, nurses must become familiar with a profile of patients' home recovery. Otherwise, implementation of teaching plans may fail to meet the expectations of patients and their families, resulting in dissatisfaction or less than optimal recovery. Time constraints imposed by the outpatient setting magnify the need to develop teaching plans that focus on the most essential needs of the ambulatory patient. Unfortunately, there is a paucity of information related to ambulatory
surgical patients' perceptions of their learning needs.

**Theoretical Framework**

Using Orem's (1995) self-care deficit theory of nursing (SCDTN) as a framework, nurses can more clearly define their roles and the importance of patient education in the ambulatory care setting. Orem's theory of self-care dictates a collaborative nurse-patient relationship to understand the patient's informational needs and the actions that support self-care.

According to Orem, it is the nurse's responsibility to obtain a complete assessment, which includes the patient's input related to the patient's existing and projected self-care "requisites". These requisites include identification and selection of valid modes of action to meet the identified needs. Nurses also act to support and develop plans of care to ensure that the necessary steps are taken to meet self-care requisites therapeutically (Dennis, 1997).

Orem's SCDTN provides one framework that supports the role of nurses in patient teaching. Central to Orem's theory is that people function and maintain life, health, and well-being by caring for themselves. However, self-care is not limited to a person providing care for himself: it may include care offered by others until the person is able
to perform self-care. Orem encourages active patient participation in the nursing process, of which patient education is one important dimension.

Orem's self-care theory is a general theory composed of three related theories. These include the theory of self-care/dependent care, the theory of self-care deficit, and the theory of nursing systems (Orem, 1995). The theory of self-care describes and explains self-care of the individual. The theory of self-care deficit describes and explains how people can be helped by nursing interventions. The theory of nursing systems describes and explains relationships that must be brought about and maintained for nursing care to be produced (Marriner-Tomey, 1994).

Further study of Orem's theory of nursing systems defines nursing as a continuing series of actions provided to assist the patient in obtaining self-care. These actions may include "wholly compensatory nursing systems", in which the patient is totally dependent upon the nurse, "partly compensatory systems", in which the patient requires some assistance from the nurse, or "supportive-educative systems" in which there are those situations in which the patient is capable of performing self-care activities but cannot do so without some assistance or guidance. When the patient requires assistance, the nurse then assumes the
responsibility for guiding, teaching, and supporting the individual (Marriner-Tomey, 1994). Certain ambulatory care services can be categorized as supportive-educative nursing systems, although, at times they may become partly compensatory nursing systems (Orem, 1995).

**Discussion of Related Research**

Clear communication and an understanding of patients' perceived needs were two of the recurring themes in the literature identified as important to patient education. Poor communication by the health care provider resulting in unrealistic expectations by the patient has been cited as one factor in decreased satisfaction (Megivern, Halm, & Jones, 1992).

**Communication**

At one time patient teaching was viewed as authoritarian and assumed patients were passive recipients without a right to have input into their own care. Patients sought medical advice solely from their physician and rarely questioned the treatment options provided. Today, the patient's medical care has ceased to be the exclusive property of physicians (Bille, 1977; Parker, Alkhteeb & Farkash, 1983; Wilson-Barnett, 1985). Patients, as consumers of health care, actively seek the information they need to make informed decisions.
In a meta-analysis of 41 independent studies, Hall, et al. (1988) found a consistent relationship between patient satisfaction and provider behavior. Poor communication by the health care team ranked as one of the leading causes of patient dissatisfaction. Vague, confusing, and contradictory information contributed to causes for concern (Otte, 1996; Parkin, 1976; Reynolds, 1978). Patients were found to have unclear expectations when "meaningless euphemisms" were used during patient teaching (Thatcher, 1996). Dissatisfaction with the amount of information received also has been identified by patients in satisfaction surveys (Waghorn, McKee, & Thompson, 1997). Patients' satisfaction with nursing care is a determinant of patients' overall satisfaction with hospital care (Abramowitz, Cote, Lazer, & Helmer, 1987). Nurses should not underestimate the impact they have on patient satisfaction as they assume greater responsibility and accountability for patient education.

Several factors have been identified that influence patient satisfaction with the health care they received. Healthier patients expressed more satisfaction than chronically ill patients (Zapka et al., 1995). Elderly patients also reported more satisfaction (Hall et al., 1988; Naylor & Shaid, 1991). Sex, social class and education were
unrelated to satisfaction in a study by Parkin (1976). Yount and Schoessler (1991) found a negative relationship between educational level and the patient's perception of needs for information and they suggested that the higher social classes may obtain information elsewhere and not rely solely on the health care team for information. However, Hall et al. (1988) reported that health care professionals tended to give more information to higher social classes, perhaps because caregivers perceive that more educated patients have a greater ability to understand additional information. In the same study, females received more information than males.

**Nursing's Role in Patient Education**

In contrast to the era of Florence Nightingale, when the physician was the decision-maker and accepted full accountability for patient care, today's expanded nursing roles promote autonomous accountability for patient care. A survey conducted by Pohl (1965) found that 37% of the nurses surveyed did not participate in patient teaching and had unclear concepts about patient teaching. As nurses began to assume a more active teaching role, many patients failed to recognize the nurse as a source of information or as one who teaches (Kreugar, 1979; Linehan, 1966). A review of 15 years of nursing literature (1952-1977) by Tilley,
Gregor, and Thiessen (1987) revealed that nurses were not always viewed as teachers. They found most patients cited the physician as the primary teacher. Nurses failed to identify themselves as being responsible for teaching and could not clearly identify the degree of independence with which they should assume the role of patient education (Parker, 1983).

Unfortunately, similar patient and nurse perceptions have continued into this decade. In a 1993 study, patients preferred information directly from the physician and viewed nurses as secondary sources (Leino-Kilpi & Vuorenheim). Interviews with nurses revealed that nurses believed they lacked credibility with patients and that patients were more apt to listen to and to discuss their concerns with their physician than with the nurse (Cohen, Hauser, & Johnson, 1994). In a 1994 study of 294 same-day surgery patients, 55% of the patients cited the physician as the primary source of information and 54% did not realize that the nurse also was responsible for their teaching (Oberle, Allen, and Lyndowski). Allen and Oberle (1993) reported 48% of the patients they studied received information from the physician only, 18% from the nurse only, and 24% from both.

In the early 1980's, the nursing literature focused
on the importance of teaching patients. Although nurses accepted the responsibility of patient teaching, barriers to effective teaching began to surface. A study of 24 nurse-patient pairs found that nurses focused on the structure and process of teaching, providing the patient with information which tended to be more medically-oriented than nursing care-oriented. In contrast, patients emphasized the outcomes of teaching and were more concerned with the impact surgery would have on their lives after discharge (Cohen et al. 1994). Even though nursing had accepted teaching as an integral part of the nursing process, a literature review provided evidence that a gap existed between the way the literature described the teaching process and the way nurses performed teaching in daily practice (Bullough, 1981; Close, 1988). Leventhal, Safer and Pangis (1993) suggested that nurses needed to modify their perception of the patient and expand their perception of the nurse.

A study of hospital registered nurses raised the question of whether nurses realize the dimensions of preoperative teaching (Yount, Edgell & Jakovec, 1990). These authors found that nurses labeled all teaching as important and questioned the nurse's ability to set priorities in patient teaching. Takahashi and Bever (1989)
found that much of the pre-operative assessment in ambulatory surgery could be categorized as medical-legal requirements. Castledin (1985) judged nursing care by the nurse's ability to identify patient problems based on the priority of needs identified through assessment. The same can be said of the teaching process where time constraints limit the quantity of materials which can be presented. Rowe (1987) warned that what professionals identified as patient learning goals were no more than goals predetermined by the nurse. Uncertainty in the teaching role also may cause the nurse to delegate the teaching back to the physician (Boylan, 1982). Studies (Leventhal et al., 1983; McMillan, 1984) indicate that health care professionals often underestimate the patient's knowledge and perceptions about disease. Theories seem to fail when teaching is based entirely upon medical facts instead of individual patient assessment, suggesting that nurses should validate patients' preferences and avoid making assumptions about patient learning needs.

Assessment of learning needs is the key to effective education (Narrow, 1979; Redman 1993). The uniqueness of each patient is supported by discovering what each patient already knows, wants to know, and needs to know (Wilson-Barnett, 1985). The most crucial stage
of the teaching process involves the nurse’s skill in determining the main priorities in providing instructions (Close, 1988). For teaching to be effective it must be based upon the patient’s particular learning needs (Corkadel & McGlashan, 1983). Teaching patients what they already know, or irrelevant material, is a waste of time and energy that leads to frustration and confusion for the patient (Spicer, 1982).

Nurses' and Patients' Perceptions of Learning Needs

Studies conducted in inpatient settings reveal a significant deficiency between the perceptions of the nurse and those of the patient having surgery in an inpatient setting. An early study by Whiting (1958), cited by White (1972), compared the perceptions of patients and nurses on the importance of 100 common nursing activities. Whiting found significant differences of opinions between the two groups. A similar study by White (1972) found differences when they compared the perceptions of nurses and patients regarding 50 selected nursing activities. The patients were more concerned with the physical aspects of care while the nurses identified psychosocial aspects of care. Interestingly, both groups found preparation for discharge of relatively little importance. Dodge (1972) found that patients and nurses disagreed about the information each
viewed as important. Dodge concluded that the information patients viewed as important was information they had not received during discharge teaching.

Aspinall (1975) and Meissner (1980) investigated whether patients were capable of identifying their own health status when administered a self-assessment questionnaire. Both studies found that the patients' input facilitated the nurses' recognition of patient problems.

Roberts (1981) conducted the first studies that directly compared the perceptions of nurses and patients regarding patient concerns. Of the 21 problems listed, 12 areas were not shared by the nurses and patients. Only the patient group identified self-care as a concern. Overall agreement reported an average nurse-patient agreement level of only 19.53%. Lauer, Murphy, and Powers (1982) studied the perceptions of nurses and cancer patients of the importance of 36 informational needs and found significant differences between nurses and patients on 20 of the items. The findings suggested that patients will follow through with self-care when their concerns are understood and they are encouraged to participate in their own self-care. Johnson (1989) also found that patients' perceived information needs were different from those perceived by the nurse. Nurses focused more on the technical aspects of
care while patients were more interested in the psychosocial aspects (Ludwig-Beymer et al., 1993).

Calkins et al. (1997) investigated the perceptions of physicians and patients regarding the patients' perceptions of the discharge plan and found they differed significantly. The physicians believed that 95% of their patients understood when to resume normal activities while only 58% of the patients reported that they understood. Both patients and physicians reported spending less than 15 minutes discussing discharge care.

Studies of specific populations also correspond with these general findings. Multiple studies have revealed a discrepancy between what patients and nurses deem important to understand about surgery, procedures, and treatments. Such discrepancies were found in a variety of studies, including studies of patients undergoing barium enema procedures (Schuster & Jones, 1982), oncology patients (Griffiths & Leek, 1995), cholecystectomy patients (Schwartz-Barcott, Fortin, & Kim, 1994), cardiac patients (Gerard, 1984; Karlik, 1987), and psychiatric inpatients (Sullivan & Yduelowitz, 1996).

A study by Johnson (1989) found that elderly patients' involvement in their discharge planning played a key role in maintaining their independence. When questioned about
the importance of discharge planning, the patients rated all items as "extremely important" or "very important". Yet, the nurses rated teaching on these topics as "moderately important" to "not important" on all items in the study. A similar study by Naylor and Shaid (1991) found that many needs of the elderly were unique to this population and did not necessarily match the theory about their learning needs. These findings strengthen the supposition that teaching must be individualized based on the learning needs assessment of each specific population and each unique patient. Because of methodology errors, Williamson (1978) could not draw conclusions from his findings, but suggested that future studies include patients with similar diagnoses.

More recent studies have examined the perceptions of surgical populations. In one study, only 30% of patients stated that the surgical experience was what they expected and 25% stated they received little or no information about their surgery prior to discharge. The patient had to resort to "trial and error" problem solving for concerns that are relatively common post-operatively. (Oberle et al., 1994). In a follow up of cataract patients study by Allen and Oberle (1993), only 24% of the patients stated that their surgery was what they expected. Most of the patients wished
that they had been given more information about what to expect and what they should do to take care of themselves.

Yount and Schoessler (1991) also found discrepancies between nurses' and patients' perceptions of five dimensions of pre-operative teaching: psychosocial support, situational information, patient role, sensation-discomfort, and skills training. Skills training was ranked second in priority by nurses but last in priority by patients. Both patients and nurses rated psychosocial needs as the most important dimension of pre-operative teaching. Moranville-Hunziker, Sagehorn, Conn, Feutz, and Hagenhoff (1993) surveyed patients following coronary artery bypass graft surgery and found no significant differences between the inpatient and outpatient group. A study comparing the perceptions of inpatient congestive heart failure patients and their nurses found that patients rated information more important than the nurses. Informational needs for instruction also differed between patients with acute illness and those with chronic illnesses (Schwartz-Barcott et al., 1994).

Brumfield, Kee, and Johnson (1996) replicated the study by Yount and Schoessler (1990) that focused on patients in an ambulatory surgical setting instead of the traditional inpatient setting. In the study by
Brumfield et al., patients ranked situational information as the most important and skills training as the least important. The nurses ranked psychosocial support as the most important. Moran and Kent (1995) found that overnight, short-stay patients desired more information regarding what to expect during recovery and when to expect significant improvements. They also reported that patients tend to provide more constructive criticism following discharge than while hospitalized.

The relationships between inpatients' perceived informational needs and selected sociodemographic variables were examined by Bubela et al. (1990a). Age and marital status did not influence patients' perceptions as measured by the Patient Learning Needs Scale (PLNS). Their informational needs were influenced by gender and level of education, with females desiring more information. Those who had not attended college reported higher learning needs than those who went beyond high school.

Gross and Ito (1991) interviewed women, who had had gynecological surgery, for the purpose of providing other women with the expertise and wisdom of patients who had experienced similar surgery. A common theme that ran throughout was the patients' need for a sense of control during the surgical experience.
The literature reveals less research in the area of ambulatory surgery. A study by Bostrom, Crawford-Swent, Lazar, & Helmer (1994) of post-discharge surgery patients suggested that the importance of health information increases with discharge. Discharged patients rated half of the learning need items higher than the hospitalized patients in the same study. The findings suggested that nurses should diversify teaching strategies to address not only immediate post-surgery knowledge deficits but also to focus on post-discharge needs.

Kleinbeck and Hoffart (1994) emphasized the need for nurses to understand the impact of at-home surgical recovery and encouraged modified teaching plans. Their qualitative study of 19 patients was conducted using interviews to gather information about patients' recovery periods at home. A single theme emerged, "toward the usual self", that is, the patients defined recovery as being able to resume self care activities. In another study conducted in a home visit follow up, patients measured success following surgery by their ability to return to self-care regimes. These patients reported being unable to remember instructions and often learned "by mistakes" in providing self-care (Thatcher, 1996).

The results of a telephone survey by Bostrom,
Caldwell, McGuire, and Everson (1996) identified that nurses generally provided discharge instructions based on disease-specific information, leaving other patient concerns about activities of daily living unanswered. Patient concerns included diet, bowel function, activity, and rest. The investigators suggested further evaluation is needed to establish a database from which nurses can accurately advise patients.

Summary

Rapidly evolving changes in the health care system provide continuing opportunities to investigate the learning needs of specific populations. As ambulatory surgery continues to grow (Michel & Myrick, 1990), the need for effective patient teaching will continue to increase. Nurses must seize this opportunity and begin the process of developing outpatient teaching standards.

Adult learners are motivated to learn as they experience needs related to self care (Wlodkowski, 1993). Nurses serve as key facilitators to assist the patient in identifying knowledge deficits and provide information (Redman, 1993). It is critical for nurses to have a broader knowledge of the outpatient's post-discharge recovery if they are to assist patients to successfully adjust for self-care at home following surgery. Essential to this
process is a clear understanding of patients' needs and expectations related to ambulatory surgery. Care based on needs assessment has been thoroughly explored in the literature by theorists in both practice and education. It is time for nurses to bring that level of expertise into daily practice.

This study sought to determine if there is a difference between nurses' perceptions and patients' perceptions of the ambulatory surgical patients' post-operative learning needs.
CHAPTER III

METHODOLOGY

Recent changes in the healthcare system have created new challenges in meeting outpatient learning needs. With continued growth in ambulatory surgery centers it is imperative that nursing take a proactive stance and create teaching standards designed exclusively for the outpatient. An understanding of what nurses perceive as important to teach and what patients perceive as important to learn is a prerequisite in determining the priorities of post-discharge teaching in the ambulatory setting.

Research Design

A descriptive, non-experimental design was used to examine the relationship between patients' and nurses' perceptions of discharge learning needs in an outpatient population of women undergoing gynecological surgery.

Sample

The patient sample was drawn from the ambulatory surgery patient population at two settings in the southeast. One was an outpatient surgery unit in a public tertiary care teaching hospital and the
other was a free-standing unit affiliated with a for-profit hospital.

Patients undergoing outpatient gynecological surgery during a three month data collection period were asked to participate in the study. Eligible patients included surgery patients admitted pre-operatively and discharged post-operatively the same day. Patients requiring an overnight hospital stay were excluded from the study. Study participants were limited to those 18 years of age or older. Possible types of surgery included, but were not limited to, bilateral tubal ligations, diagnostic laparascopy, biopsy, salpingectomy, oophorectomy, conization of cervix, dilation and curettage, lysis of adhesions, cystectomy, hysteroscopy, and excision of Bartholins's cyst. Because of the nature of the surgery, all patients were females.

Of the 33 nursing surveys distributed, 29 were returned, a response rate of 88%. Of the 82 patient surveys distributed, 42 patients (51%) returned them. All nurses surveyed were involved in discharge teaching for the gynecological patient receiving outpatient surgery. Sample size was limited by the number of nurses employed at each site.
**Instrumentation**

The Patient Learning Needs Scale (PLNS) by Bubela et al. (1990b) was designed to measure the discharge learning needs of adult patients. A brief description of their survey development process follows.

The original 50 item survey was designed as a self-administered questionnaire for patients 18-80 years old. It was developed to elicit patient perceptions of learning needs prior to hospital discharge to more effectively manage their health care at home.

Development of the PLNS was conducted in two stages. The first stage determined face validity, content validity, and patient comprehension. The second stage evaluated construct validity and reliability. Concurrent validity was not established due to the unavailability of parallel discharge needs scales.

To establish content validity, multiple revisions of the Patient Learning Needs Scale were submitted to clinical experts for review. Bubela et al. (1990b) initially selected 76 items from content identified through patient interviews, literature searches, and personal experiences of expert clinical nurses. Subsequent revisions were reviewed to assure accuracy and clarity.

The questions were then placed in random order
and worded in the same direction. A 6 point Likert scale was used with 0 indicating "non applicable" to 5 indicating "extremely important". The survey was designed to provide both a total score and a score for each of the factor domains. Later revisions deleted the non-applicable option. A pilot sample, conducted by Bubela et al. (1990b), of 301 adult patients resulted in further revision of the PLNS scale. After calculations of inter-item correlation, item analysis, and analysis of effects of sub-population variability, 26 items were deleted. The remaining 50 items met the criteria determined to be applicable to the majority of patients. Criteria for inclusion included: (a) less than 30% of the responses were in the does not apply category, (b) inter-item correlation was between 0.20 and 0.80, and (c) there was a wide distribution of responses on the item.

Beginning construct validity was established by factor analysis resulting in the identification of seven factors within the 50 item scale. The seven factors included (a) medications, (b) activities of daily living, (c) community and follow-up, (d) feelings related to condition, (e) treatment and complications, (f) enhancing quality of life, and (g) skin care. The correlation of the sub-scale to total scores ranged from $r = 0.69$ to 0.85 while the
intercorrelation of the sub-scale scores was \( r = 0.42 \) to 0.71. Subsequent samples reported inconsistent reliability related to the sub-factor "skin care".

The scale was again revised to reflect 40 items with a five factor sub-scale (S. Galloway, personal communication, October 21, 1997). These items were classified into one of the following domains (a) support and care in community (b) medications, (c) treatment and activities of living, (d) complications and symptoms, and (e) illness related concerns. These five factors accounted for 44.7% of the variance in the 40 item scale. See Appendix A for a listing of each factor and its related item.

A high internal consistency of the original 50 item instrument, using alpha coefficient, was reported. An alpha of 0.95 was reported for the total scale with a range of 0.69 to 0.88 range for the seven factors. The revised 40 item instrument maintained a coefficient of 0.95 for the total and a range of 0.76 - 0.91 for the five factors.

**Patient Survey**

In addition to using the 40 item PLNS scale, the patient survey instrument used for this study also included a demographic section and an item ranking scale designed to identify patients' top five learning needs (Appendix A). Patient confidentiality was protected by separating the
consent form from the survey after the patient had signed it. No identifying marks were used on the survey. According to Bubela et al. (1990b) the PLNS could be completed in approximately 20 minutes.

The PLNS questionnaire readability level was determined to be at an eighth grade level using the SMOG and Flesch formula (Redman, 1993). It has been estimated that the literacy rate of many Americans is at, or below, an 8th grade reading level. Research supports that an individual's reading level score is as much as three grade levels below the educational level completed (Redman, 1993). The researcher altered 15 questions to reduce the readability level by substituting synonyms for some words. For example "complications" was replaced with "problems". This brought the items to a 6th grade reading level (Appendix C).

The first section of this instrument focused on demographic data. Questions included type of surgery, age, occupation, education, marital status, and race. The patient also was asked to rate how much assistance was needed the day after surgery.

The second section of this survey was the Patient Learning Needs Scale (Bubela et al., 1991b) which was described previously and which was adapted by the
researcher. The patient was instructed to rate the importance of each of the 40 items in managing self-care at home after discharge. Scoring was based on a 5 point Likert scale ranging from 1 indicating "not important" to 5 indicating "extremely important".

In the third section of the survey, the patient was instructed to list the five items considered most important from the 40 item survey. Finally, patients were asked to circle the one item they believed was the most important to them from their list of five.

A survey expert, a statistician, and registered nurses within the College of Health Professions reviewed this instrument for clarity, and changes were made prior to distribution of the pilot survey. A pilot test of the three part survey instrument was conducted prior to distribution of the final survey. Of the 25 pilot surveys distributed, 11 were returned (44%). The only revision made was on a question in the demographic section regarding level of education. The question format was modified from an open question to a checklist of various educational levels. No other changes were deemed necessary.

Nurses' Survey

The survey instrument completed by the registered nurse sample included demographic data related to age,
education, total years work experience as a registered nurse, total years work experience in present position, gender, and race. The nurses were also asked to rate how much assistance they believed patients needed after surgery.

The second section of the nurse survey was identical to the patient survey except that the readability level was not changed. Also, the registered nurse sample was instructed to rate the items in terms of how important they believed each item was for patients to know at the time of discharge. The same 5 point Likert scale was used.

The final section of the survey asked the nurse to select five of the 40 items that they believed were the most important. Then the nurse was asked to circle the most important item from these five for patients to know.

The nurse pilot study consisted of two sections. Part A asked the nurse to rate the items as they applied to procedures that do not require a surgical incision. Part B was based on those procedures that require a surgical incision. Otherwise, the two parts were identical.

The inclusion of both parts in the pilot survey was used to test the assumption that nurses view the discharge needs of this population as a whole regardless of the presence of an incision. A two tailed paired t-test was
performed at an alpha level of 0.05. No significant difference was found and therefore the final nurse survey included only one version (Appendix D).

**Data Collection**

Patient surveys were distributed by a resource person appointed in each area surveyed. A clinician from each setting was interviewed and chosen by the surveyor to act as the resource person for that setting. The resource person accepted the responsibility to obtain consent, answer patient questions, and distribute the patient surveys. The purpose and method of survey distribution was reviewed by the investigator and written instructions were given to each resource person.

Patients were asked individually to participate in the study and sign the consent form. Participation was voluntary and patients were instructed not to put their names on the returned survey. The patient questionnaires were distributed prior to discharge from the ambulatory surgery setting.

By signing the consent to participate the patient agreed to complete the survey within three days after surgery and return it by mail. A cover letter, included with each questionnaire, explained the purpose of the survey. A self addressed stamped envelope was also
included. The completed survey was mailed directly to the investigator.

The assigned resource person also distributed and collected the completed nurse surveys. Confidentiality was maintained by collection of the completed surveys in an envelope provided by the resource person. No identifying information was required on the completed questionnaire. Participation was voluntary and consent was implied by return of the survey.

Analysis of Data

Both the patients' and nurses' response data were analyzed using the same methods.

The demographic data collected in the first section of the surveys were analyzed and reported using descriptive methods. When applicable, the mean score, the standard error of the mean, and the range were reported. Nominal variables were examined by percentages and frequency calculations.

The survey's second section consisted of the 40 item Patient Learning Needs Scale, using a 5 point Likert scale. Higher scores indicate that more importance was placed on the item. An unweighted mean was calculated for each item. Evaluation of factor differences between nurses' and patients' scores was determined by student t-tests.
Bonferroni correction was used to decrease the probability of making a Type I error. An alpha level of $p < 0.01$ was accepted as significant.

Analysis of the third section of the survey was determined by ranking the frequency of the five items deemed most important by the participants. The single highest ranked item of importance was also compared.
The importance of the learning needs assessment is well documented in both nursing and educational literature. As the number of outpatient surgery centers increase so will the need for concise, efficient outpatient post-discharge education. The focus of this study was to examine the differences between nurses' and patients' perceived post-operative learning needs in an outpatient gynecological setting.

The survey instrument used in the data collection consisted of three sections. The sections were (a) the 40 item Patient Learning Needs Scale (Bubela et al., 1990b, S. Galloway, personal correspondence, October 21, 1997), (b) a demographic section, and (c) an item ranking scale designed to identify the top five learning needs perceived as most important, including the item perceived as most important overall. The nurses' and patients' survey was identical except for the demographic sections. Each section of the survey will be discussed separately.
Presentation of Findings

Demographic data

Out of a possible 33 responses, 29 nurses (88% return rate) returned the survey. The sample (n=29) included 20 nurses from site A and 9 nurses from site B. Nurses' ages ranged from 28 to 60 with a mean age of 41 ± 1. The nurses averaged 15 years of nursing experience with a range of 1 to 34 years. The years of experience in an ambulatory surgery setting ranged from 2 months to 10 years with an average length of 4 years. The majority of nurses had a bachelor's degree (38%) while 10% had a master's degree. The remaining 52% of the respondents were equally divided with either an associate degree or diploma in nursing. No significant differences were found between the two groups of nurses by age, total years of nursing experience, years experience in ambulatory surgery or educational level. All of the nurses were female and 93% were Caucasian.

Of the 82 patient questionnaires distributed, 42 were returned (51% return rate). The sample (n=42) consisted of 31 from site A and 11 from site B. Patient ages ranged from 20 to 71 with a mean age of 37 ± 2 years. The majority (78%) of respondents were Caucasian. Table 1 describes the educational level, marital status, and the type of surgery of the patients. One patient did not identify the type of
surgery on the survey. No significant differences ($p > .05$) in the patients' sample were found between the two sites for education, marital status, type of surgery, or age.

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Table 1

Demographic Data of the Patients ($n = 42$)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EDUCATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 12th grade</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td>High school graduate</td>
<td>14</td>
<td>33.3</td>
</tr>
<tr>
<td>Some college</td>
<td>11</td>
<td>26.2</td>
</tr>
<tr>
<td>College graduate</td>
<td>14</td>
<td>33.3</td>
</tr>
<tr>
<td><strong>MARITAL STATUS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>30</td>
<td>71.4</td>
</tr>
<tr>
<td>Widow</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Single</td>
<td>8</td>
<td>19.0</td>
</tr>
<tr>
<td>Divorced</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>TYPE OF SURGERY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>incisional</td>
<td>27</td>
<td>64.3</td>
</tr>
<tr>
<td>non-incisional</td>
<td>14</td>
<td>33.3</td>
</tr>
<tr>
<td>unknown</td>
<td>1</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Note. One patient did not indicate the type of surgery.
Amount of Assistance Needed

Orem's (1995) self-care deficit theory describes self-care as a series of actions that range from a patient's total dependence upon others for care to complete independence in providing one's own care. Both patients and nurses were asked to rank how much care they perceived an ambulatory patient needed the day after surgery. As shown in Figure 1 patients have a broader view of the amount of assistance they perceive as needed. Nurses ranked all patients as needing either "some" or "a lot of" assistance.
Figure 1. A comparison of the amount of assistance perceived as needed post-operatively by patients and nurses.

Amount of Assistance Needed

Comparison of Patients and Nurses

Note:
None: no assistance needed
Some assistance needed
A lot of assistance needed
Full assistance needed

*aNone of the nurses responded that either "no assistance" or "total assistance" was needed."
Patient Learning Needs Assessment Factor Analysis

The 5 factors of the 40 item patient learning needs included "Support and Care in the Community" (10 items), "Medications" (8 items), "Treatment and Activities of Living" (8 items), "Complications and Symptoms" (8 items), and "Illness-Related Concerns" (6 items).

A comparison between the nurses' and patients' responses was determined by ranking the mean score of each factor. Six patient surveys were excluded from this analysis due to the omission of one or more responses to the 40 items, therefore only 36 patients' responses were used for this section.

Nurses (n=29) ranked factor 2, Medications, as the most important factor in patient discharge instructions. Patients (n=36) ranked Factor 4, Complications and Symptoms, as most important. Comparison of the other factors is shown in Table 2.
Table 2

Comparison of Factor Ranking by Patients\(^a\) and Nurses\(^b\)

<table>
<thead>
<tr>
<th>Nurses</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medications</td>
<td>1. Complications and symptoms</td>
</tr>
<tr>
<td>2. Complications and symptoms</td>
<td>2. Support and care in the community</td>
</tr>
<tr>
<td>3. Support and care in the community</td>
<td></td>
</tr>
<tr>
<td>4. Treatment and activities of living</td>
<td>4. Treatment and activities of living</td>
</tr>
<tr>
<td>5. Illness-related concerns</td>
<td>5. Illness-related concerns</td>
</tr>
</tbody>
</table>

\(^a\) \(n = 36\)

\(^b\) \(n = 29\)
The statistical differences between the nurses' and patients' factor mean scores are shown in Table 3. The only significant difference between the two groups was Factor 2 (Medications).

Table 3
Statistical Differences Between the Factor Mean Scores.

<table>
<thead>
<tr>
<th>Factor</th>
<th>t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Support and Care in the Community</td>
<td>0.265</td>
</tr>
<tr>
<td>2. Medications</td>
<td>0.001*</td>
</tr>
<tr>
<td>3. Treatment and Activities of Living</td>
<td>0.597</td>
</tr>
<tr>
<td>4. Complications and Treatment</td>
<td>0.020</td>
</tr>
<tr>
<td>5. Illness-Related Concerns</td>
<td>0.163</td>
</tr>
</tbody>
</table>

*P < 0.01

Individual Items Ranked by Means

Each of the 40 items were ranked according to mean. Nurses ranked 78% of the items higher than the patients. Using Kendall's tau, a significant difference (τ = 0.0005) was found in the ranking of individual items. Table 4 compares the means of the responses provide by the respondents.
Table 4

Comparison of Individual Items by Mean

<table>
<thead>
<tr>
<th>Questions</th>
<th>Nurses n=29</th>
<th>Patients n=40</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What to do if I have trouble urinating.</td>
<td>4.58</td>
<td>4.44</td>
</tr>
<tr>
<td>2. How to prepare the foods I am to eat.</td>
<td>2.90</td>
<td>3.09</td>
</tr>
<tr>
<td>3. How to prevent a complication from occurring.</td>
<td>4.62</td>
<td>4.32</td>
</tr>
<tr>
<td>4. How to take each medicine.</td>
<td>4.90</td>
<td>4.41</td>
</tr>
<tr>
<td>5. What symptoms I may have related to my illness.</td>
<td>4.66</td>
<td>4.53</td>
</tr>
<tr>
<td>6. When to take each medicine.</td>
<td>4.83</td>
<td>4.26</td>
</tr>
<tr>
<td>7. How this illness will affect my life.</td>
<td>4.10</td>
<td>4.21</td>
</tr>
<tr>
<td>8. How to recognize a complication.</td>
<td>4.93</td>
<td>4.62</td>
</tr>
<tr>
<td>9. How this illness will affect my future.</td>
<td>4.07</td>
<td>4.62</td>
</tr>
<tr>
<td>10. How to care for my wound properly.</td>
<td>4.86</td>
<td>4.35</td>
</tr>
<tr>
<td>11. What complications might occur from my illness.</td>
<td>4.62</td>
<td>4.20</td>
</tr>
</tbody>
</table>

(table continues)
<table>
<thead>
<tr>
<th>Questions</th>
<th>Nurses n=29</th>
<th>Patients n=40</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. How to recognize my feelings toward my illness.</td>
<td>3.58</td>
<td>3.44</td>
</tr>
<tr>
<td>13. How to contact community groups for my health condition.</td>
<td>3.41</td>
<td>3.00</td>
</tr>
<tr>
<td>14. When I can take a bath or a shower.</td>
<td>4.33</td>
<td>4.15</td>
</tr>
<tr>
<td>15. How to talk to family/friends about my illness.</td>
<td>3.38</td>
<td>3.18</td>
</tr>
<tr>
<td>16. How much rest I should be getting.</td>
<td>3.83</td>
<td>3.74</td>
</tr>
<tr>
<td>17. How to get through the &quot;red tape&quot; in the health care system.</td>
<td>3.20</td>
<td>3.85</td>
</tr>
<tr>
<td>18. What the possible side effects of my treatment are.</td>
<td>4.59</td>
<td>4.35</td>
</tr>
<tr>
<td>19. What to do if I have trouble with my bowels.</td>
<td>4.10</td>
<td>4.26</td>
</tr>
<tr>
<td>20. What to do if I cannot sleep properly.</td>
<td>3.76</td>
<td>3.82</td>
</tr>
<tr>
<td>21. How to manage the symptoms I may experience.</td>
<td>4.48</td>
<td>3.91</td>
</tr>
<tr>
<td>22. How I can avoid stress.</td>
<td>3.31</td>
<td>3.76</td>
</tr>
</tbody>
</table>

(table continues)
<table>
<thead>
<tr>
<th>Questions</th>
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<th>Patients n=40</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. What physical exercise I should be getting.</td>
<td>3.69</td>
<td>3.91</td>
</tr>
<tr>
<td>24. What the purposes of my treatment are.</td>
<td>4.17</td>
<td>3.91</td>
</tr>
<tr>
<td>25. Why I need to take each medicine.</td>
<td>4.72</td>
<td>3.88</td>
</tr>
<tr>
<td>26. Where I can get my medication.</td>
<td>4.17</td>
<td>3.47</td>
</tr>
<tr>
<td>27. Where I can get help in handling my feelings about my illness.</td>
<td>3.49</td>
<td>3.29</td>
</tr>
<tr>
<td>28. Which foods I can and cannot eat.</td>
<td>3.80</td>
<td>3.38</td>
</tr>
<tr>
<td>29. How to prevent my skin from getting red.</td>
<td>3.17</td>
<td>2.97</td>
</tr>
<tr>
<td>30. Which vitamins and supplements I should take.</td>
<td>2.90</td>
<td>3.32</td>
</tr>
<tr>
<td>31. How to get through the &quot;red tape&quot; to get services at home.</td>
<td>3.07</td>
<td>2.76</td>
</tr>
<tr>
<td>32. Who to talk to about my concerns about death.</td>
<td>3.62</td>
<td>2.88</td>
</tr>
</tbody>
</table>

(table continues)
<table>
<thead>
<tr>
<th>Questions</th>
<th>Nurses n=29</th>
<th>Patients n=40</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. How to prevent my skin from getting sore.</td>
<td>3.41</td>
<td>3.06</td>
</tr>
<tr>
<td>34. How to manage my pain.</td>
<td>4.76</td>
<td>3.91</td>
</tr>
<tr>
<td>35. When to stop taking each medication.</td>
<td>4.62</td>
<td>3.85</td>
</tr>
<tr>
<td>36. How each medication works.</td>
<td>4.21</td>
<td>4.08</td>
</tr>
<tr>
<td>37. What to do if I have a reaction to a medication.</td>
<td>4.82</td>
<td>4.29</td>
</tr>
<tr>
<td>38. What physical activities I cannot do such as lifting.</td>
<td>4.66</td>
<td>4.50</td>
</tr>
<tr>
<td>39. The possible reactions to each medication.</td>
<td>4.62</td>
<td>4.35</td>
</tr>
<tr>
<td>40. Where I can get help for family to deal with my illness.</td>
<td>3.59</td>
<td>2.88</td>
</tr>
</tbody>
</table>
Question # 8 "How to know if there is a problem," scored the highest mean for both groups (nurses' mean = 4.93, patients' mean = 4.62). Patients ranked the following nine items higher than the nurses:

How to prepare the foods I am to eat. (Item #2)
How this illness will affect my life. (#7)
How this illness will affect my future. (#9)
How to get through the health care system. (#17)
What to do if I have trouble with my bowels. (#19)
What to do if I cannot sleep. (#20)
How I can avoid stress. (#22)
What exercise I should be getting. (#23)
Which vitamins and supplements I should take. (#30)

Five Most Important Items Ranked by Frequency/Percentage

Both patients (n=40) and nurses (n=29) identified item #8 (How to recognize a complication) most frequently. This was the only choice identified by both nurses and patients among the top five items of importance. Two patient questionnaires were omitted due to incomplete answers in this section. Figures 2 and 3 describe the frequency that items were identified by nurses and patients as being "most important." Six items are listed for the nurses because three items had equal frequencies. Table 5 compares the
percentage of responses nurses' and patients' identified as the five most important post-operative learning needs.

Four of the five items chosen as most important by patients belonged in Factor 4 (Complications and Symptoms). The fifth item (What the possible side effects of my treatment are) was categorized under Factor 3 (Treatment and Activities of Living).

In contrast, nurses chose items from each of the five factor categories with the exception of Factor 3 (Treatment and Activities of Living).
Figure 2. The six\textsuperscript{a} most important post-operative learning needs identified by nurses compared to the patients' responses of the same items\textsuperscript{b}.

Note.

A = How to take each medicine. (Item #4)

B = When to take each medicine. (#6)

C = What to do if I have trouble urinating. (#1)

D = How to manage my pain. (#34)

E = How to care for my wound properly. (#10)

F = How to recognize a complication. (#8)

\textsuperscript{a} Three of the nurses' responses were equal in frequency resulting in six top choices.

\textsuperscript{b} The numbers on each bar represent the total number of responses to the question.
Figure 3. The five most important post-operative learning needs identified by patients compared to the nurses' responses of the same items.\(^a\)

Note.

A= What complications might occur from my illness. (Item #11)

B= How to prevent a complication from occurring. (#3)

C= What symptoms I may have related to my illness. (#5)

D= What the possible side effects of my treatment are. (#18)

E= How to recognize a complication. (#8)

\(^a\) The numbers on each bar represent the total number of responses to the question.
Table 5

Comparison of Most Important Learning Needs by Percentages

<table>
<thead>
<tr>
<th>Questions</th>
<th>Nurses n=29</th>
<th>Patients n=40</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What to do if I have trouble urinating.</td>
<td>31.0</td>
<td>15.0</td>
</tr>
<tr>
<td>2. How to prepare the foods I am to eat.</td>
<td>0</td>
<td>12.5</td>
</tr>
<tr>
<td>3. How to prevent a complication from occurring.</td>
<td>13.8</td>
<td>35.0</td>
</tr>
<tr>
<td>4. How to take each medicine.</td>
<td>31.0</td>
<td>12.5</td>
</tr>
<tr>
<td>5. What symptoms I may have related to my illness.</td>
<td>27.5</td>
<td>35.0</td>
</tr>
<tr>
<td>6. When to take each medicine.</td>
<td>31.0</td>
<td>12.5</td>
</tr>
<tr>
<td>7. How this illness will affect my life.</td>
<td>6.9</td>
<td>17.5</td>
</tr>
<tr>
<td>8. How to recognize a complication.</td>
<td>86.2</td>
<td>47.5</td>
</tr>
<tr>
<td>9. How this illness will affect my future.</td>
<td>0</td>
<td>17.5</td>
</tr>
<tr>
<td>10. How to care for my wound properly.</td>
<td>75.9</td>
<td>22.5</td>
</tr>
<tr>
<td>11. What complications might occur from my illness.</td>
<td>17.2</td>
<td>30.0</td>
</tr>
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</table>

(table continues)
<table>
<thead>
<tr>
<th>Questions</th>
<th>Nurses (n=29)</th>
<th>Patients (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. How to recognize my feelings toward my illness.</td>
<td>0</td>
<td>7.5</td>
</tr>
<tr>
<td>13. How to contact community groups for my health condition.</td>
<td>3.4</td>
<td>0</td>
</tr>
<tr>
<td>14. When I can take a bath or a shower.</td>
<td>3.4</td>
<td>17.5</td>
</tr>
<tr>
<td>15. How to talk to family/friends about my illness.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16. How much rest I should be getting.</td>
<td>0</td>
<td>7.5</td>
</tr>
<tr>
<td>17. How to get through the &quot;red tape&quot; in the health care system.</td>
<td>0</td>
<td>12.5</td>
</tr>
<tr>
<td>18. What the possible side effects of my treatment are.</td>
<td>86.2</td>
<td>47.5</td>
</tr>
<tr>
<td>19. What to do if I have trouble with my bowels.</td>
<td>3.4</td>
<td>12.5</td>
</tr>
<tr>
<td>20. What to do if I cannot sleep properly.</td>
<td>3.4</td>
<td>12.5</td>
</tr>
<tr>
<td>21. How to manage the symptoms I may experience.</td>
<td>6.9</td>
<td>12.5</td>
</tr>
<tr>
<td>22. How I can avoid stress.</td>
<td>0</td>
<td>15.0</td>
</tr>
</tbody>
</table>

(table continues)
<table>
<thead>
<tr>
<th>Questions</th>
<th>Nurses n=29</th>
<th>Patients n=40</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. What physical exercise I should be getting.</td>
<td>0</td>
<td>5.0</td>
</tr>
<tr>
<td>24. What the purposes of my treatment are.</td>
<td>6.9</td>
<td>5.0</td>
</tr>
<tr>
<td>25. Why I need to take each medicine.</td>
<td>13.8</td>
<td>5.0</td>
</tr>
<tr>
<td>26. Where I can get my medication.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>27. Where I can get help in handling my feelings about my illness.</td>
<td>0</td>
<td>2.5</td>
</tr>
<tr>
<td>28. Which foods I can and cannot eat.</td>
<td>0</td>
<td>2.5</td>
</tr>
<tr>
<td>29. How to prevent my skin from getting red.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>30. Which vitamins and supplements I should take.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>31. How to get through the &quot;red tape&quot; to get services at home.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>32. Who to talk to about my concerns about death.</td>
<td>0</td>
<td>2.5</td>
</tr>
</tbody>
</table>

(table continues)
<table>
<thead>
<tr>
<th>Questions</th>
<th>Nurses n=29</th>
<th>Patients n=40</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. How to prevent my skin from getting sore.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>34. How to manage my pain.</td>
<td>51.7</td>
<td>15.0</td>
</tr>
<tr>
<td>35. When to stop taking each medication.</td>
<td>3.4</td>
<td>2.5</td>
</tr>
<tr>
<td>36. How each medication works.</td>
<td>3.4</td>
<td>2.5</td>
</tr>
<tr>
<td>37. What to do if I have a reaction to a medication.</td>
<td>24.1</td>
<td>27.5</td>
</tr>
<tr>
<td>38. What physical activities I cannot do such as lifting.</td>
<td>24.1</td>
<td>15.0</td>
</tr>
<tr>
<td>39. The possible reactions to each medication.</td>
<td>6.9</td>
<td>20.0</td>
</tr>
<tr>
<td>40. Where I can get help for family to deal with my illness.</td>
<td>0</td>
<td>2.5</td>
</tr>
</tbody>
</table>
Six of the survey items were not identified as one of the top five considered most important by any of the respondents (nurses or patients). These items were:

Factor 1 (Support and Care in the Community)

#29 How to prevent my skin from getting red.
#31 How to get through the "red tape" to get services at home.

Factor 2 (Medication)

#26 Where I can get my medications.
#33 How to prevent my skin from getting sore.

Factor 3 (Treatment and Activities of Living)

#30 Which vitamins and supplements I should take.

Factor 5 (Illness-Related Concerns)

#15 How to talk to family/friends about my illness.

_**Item Identified as the Most Important Overall**_

"How to recognize a complication" (item 8) was most frequently chosen as the most important item of importance by both nurses and patients.
Chapter V

Discussion

The growth of ambulatory surgical centers coupled with professional mandates of consumer involvement in health care has created new opportunities for research. Previous studies of inpatients have identified a gap between the perceptions of patients and nurses (Brumfield et al., 1996; Dodge, 1972; Roberts, 1981; Yount & Schoessler, 1990). However, examination of the learning needs of the ambulatory surgery population is scant.

Outpatient teaching standards, based upon both the patients' input and the nurses' expertise must address issues that arise during the post-operative recovery in the home environment. In contrast to the inpatient setting, nurses no longer witness the patients' post-operative experiences. Patients supported by the help of friends and families, provide the post-operative care. For these reasons this study was designed to compare nurses' and patients' perceptions of the post-operative learning needs of ambulatory surgical patients. The insights provided by this study may enhance the delivery of outpatient
teaching in the future.

**Summary of findings**

**Demographic Data**

Due to the small sample size, statistical analysis of the sub-sample demographic data was not possible. However, several interesting findings emerged.

The mean age of patients (37) was lower than that reported in two similar inpatient studies that used the same instrument. Those studies reported mean ages of 54 years (Bostrom et al., 1994; Bubela et al. 1990b). Cruz (1990) identified ambulatory surgery as "healthy surgery" and the younger sample of this study may support that supposition.

Bubela et al. (1990b) reported that patients who had not attended college reported higher learning needs than those with higher education. This study found 60% of the respondents reported at least some college while only 7% had less than a high school diploma or equivalent. Unreturned surveys (49%) may be related to the respondent's educational level.

**Perceived Level of Assistance Needed**

Orem's self-care theory defines nursing as a continuing series of actions provided to assist the patient in obtaining self-care (Marriner-Tomey, 1994). It is the
operatively and continues through recovery. Improved technology such as videos, web sites, and prerecorded telephone messages may provide patients opportunities to review educational materials specific to their procedures. Availability of brochures, medication cards, or written instructions providing directions and telephone numbers may serve to provide patients with minor, yet important information.

Bille (1981) suggests "therapeutic seeding" techniques that plant ideas concerning patient teaching in a patient mind resulting in increased patient involvement. Patients may be given a list of questions related to self-care activities and home activities to promote planning for the post-operative phase of recovery. For example, patients could be encouraged to arrange for car pools if driving is prohibited or completing laundry prior to surgery if lifting limits are required. Individual concerns could then be discussed with the nurse and recommendations made. Availability of these questions may be extremely important for patients undergoing surgery for the first time or those that lack initiative or fear asking "too many questions." Pre-and post-operative telephone calls provide additional support and follow-up to patients. Using a variety of teaching methods throughout the surgical procedure provides
both groups.

Nurses and patients identified the same three factors as most important, but ranked them differently. Nurses identified "Medications" as the most important followed by "Complications and Symptoms" and "Support and Care in the Community." The only statistical difference noted between the five factors was in the patients' and nurses' responses related to "Medications" ($p = 0.001$). Several nurses, following the completion of the surveys, remarked that it was difficult to choose among the medication questions and that all aspects of medication were important. Although not statistically significant, "Complications and Treatment" was the only other factor to approach a significant difference ($p = 0.02$).

Patients ranked "Complications and Symptoms" as the most important factor followed by "Support and Care in the Community" and, lastly, "Medications". These findings are similar to the findings of inpatients done by Bubela et al. (1990b) and Bostrom et al. (1994). However, their results were reported using the 50 item (7 factor) version of the Patient Learning Needs Scale (PLNS) instead of the revised 40 item (5 factor) used in this study, which limited direct factor to factor analysis.

Bostrom et al. (1994) suggested that based upon
their study and a similar study by Bubela et al. (1990b) the "priority rankings for patient learning need categories are fairly homogenous, but within each category items may need to be individualized to meet specific patient learning needs" (p. 87). Bostrom reported that most of the patients' identified needs increased after discharge. Explanation of this was attributed to the patients' attempts to regain autonomy of their self-care. Bostrom's sample consisted of recently discharged patients and cannot be directly compared to the outpatient setting.

Rank ordering of the five top items deemed as most important to know revealed patients and nurses did not perceive the same priorities. As shown in Table 5, several items reveal discrepancies based on the opinions of nurses and patients. For example, wound care was identified by 76% of the nurses as one of the top five learning needs in contrast to 23% of the patients. Patients placed more emphasis on food preparation, complication prevention, effects of illness on their future, and activities of daily living. This supports Kleinbeck and Hoffart (1994) in that teaching strategies need to be expanded beyond medical care to include specific home care activities.

Of the 40 items, only Item 8 (How to recognize a complication) was chosen by both the patients and nurses in
this section of the survey. Also, this item was identified by both groups more often than any other item. No other items were reported by both groups in this section.

Lauer et al. (1982) concluded that nurses possess more insight about disease and treatment and therefore identify more medically oriented topics. The items chosen as most important to the nurses in this study related to medications, pain, wound care, and urination. Patients identified concerns of complications, symptoms, and side effects of treatment.

These findings may indicate that nurses place more emphasis on these items during discharge teaching, thus providing the patient adequate knowledge relative to these topics. Other explanations may include previous surgical experiences of the patients and/or family resulting in a better understanding of basic care.

**Conclusions**

The primary purpose of this study was to identify whether a gap existed between the nurses' and patients' perceptions in an ambulatory setting. The results suggest statistically significant differences do exist between nurses' and patients' perceptions of discharge learning needs. Individual items, as well as factors of the PLNS identified different priorities by each group. Findings
from this study support the contention that assessment of individual learning needs to be a collaborative process between the nurse and patient to provide relevant, concise outpatient discharge teaching for effective home care and recovery.

Recommendations

Although this study indicates that a gap exists between the perceptions of patients and nurses related to the perceived discharge needs of the outpatient gynecological patient, the small sample size prohibits generalization to the population. The following suggestions are made for future investigation of this topic:

1. Replication of this work in other institutions using a larger sample over a longer period of time would strengthen findings of the study.

2. Identification and comparison of other ambulatory surgery diagnostic categories are needed before generalization of all outpatient teaching needs can be identified.

3. An additional section for comments may have elicited insight into issues deemed important by patients and nurses. The qualitative aspect of research compliments descriptive studies by providing depth to the data collected.
4. A follow-up phone call or second notice should be incorporated into the survey design to increase the return rate because the use of self-reporting questionnaires free from all identifying marks limited the investigator's ability to follow-up on unreturned surveys.

5. Attempts should be made to distribute the questionnaires pre-operatively. A combination of post-operative medications, such as the amnesiacs, may have contributed to patients "forgetting" to return the survey. Inclusion of family during the instructions may serve to remind patients post-operatively of the importance of returning the survey promptly.

6. Additional studies are needed to create valid and reliable instruments for use in ambulatory surgery. Review of the literature reveals few investigational tools available in the field of ambulatory surgery. Tools designed for inpatients may not capture important aspects of ambulatory care.

7. A shorter, modified version of the PLNS would support other research designs such as phone surveys, one-to-one interviews, or home visits.

8. Further studies could either extend data collection over a one-year period or compare the first half of the year
to the end of the year. Return rates may be influenced by the time of year the surveys are collected. The pilot study conducted prior to the end of the year yielded a larger gynecological population. Perhaps end of the year insurance deductibles, accumulated leave from work, or the holidays may have influenced the number of responses.

9. Commitment by the resource person to actively support the research project is essential. Initially, three sites agreed to participate in the study. Later, one site decided not to participate due to other commitments and lack of personnel to distribute the patient questionnaires. A second resource person was appointed to the second site after the first resource person relocated to another city. As ambulatory surgery grows, time constraints on the nurse also increases, and distribution of surveys may not always be at the top of the priority list. Providing a formal letter of intent may have increased the resource person's commitment to the project.

Additional recommendations underscore the need for further research related to several issues implied by the results of this study.

Research investigating the effect of age may provide insight into individual population needs. Studies by
Johnson (1989) identified differences of perceptions in the elderly population. Further studies based on age may assist the nurse to understand outpatients' care needs based upon developmental theories.

Similarly, more research is needed to provide effective teaching strategies for patients with a high school education or less. The 49% of unreturned surveys in this study may have been related to the respondents' education level. Perhaps other investigative strategies, such as phone calls or one-on-one interviews, may be needed to capture this segment of the population.

Further research, comparing patients' perceptions of learning needs pre-and post-operatively, may identify which information patients view as most important and whether the surgical process changed their initial perceptions and expectations. Post-operative follow-up phone calls may provide additional teaching opportunities by allowing the patient/family time to ask questions and discuss individual concerns related to home recovery.

A study of complications occurring post-operatively during home recovery could expand the nurse's understanding of the most prevalent safety issues. Thus, providing a basis for deciding which information patients must receive.
Implications for Practice

Although the results of this study cannot be generalized, it supports previous findings that differences of patients' and nurses' perceptions of learning needs exist in a variety of patient care settings. The most important aspect of these findings is not that differences exist, but that more research is needed in the outpatient setting.

Do differences in patients' and nurses' perceptions of post-operative learning needs adversely affect the patients' surgical outcomes? Additional research is needed to measure actual outcomes in relation to patient teaching, but questions surface related to patient safety needs. As we approach the 21st century and more complex procedures shift to the outpatient arena, how will the nurse determine the priorities of patient teaching? Historically, nursing care has been delivered at the bedside where the nurses' expertise and knowledge are readily available in the event of unforeseen complications. What criteria will be used to determine the basis for discharge teaching? Many factors may influence the answer: safety concerns, outcome studies, mortality or morbidity records, readmission rates, legal issues, financial concerns, or perhaps, patient satisfaction reports. Further investigation of the content
of outpatient teaching and its impact on patients' is
needed. The transformation of health care delivery
necessitates modification of patient education approaches.
Steps are needed to create seamless care, beginning in the
physician's office or pre-operative clinic and continuing
throughout the transition to home. Teaching strategies,
including pre-operative, post-operative, and post-
discharge, as well as prevention and health promotion,
should be integrated as the patient moves though the phases
of the outpatient surgical process.

Opportunities to teach are often hampered by
personnel shortages, clinical duties, and heavy work load
demands (Cruz, 1990; Wetchler 1986). Educational barriers
in ambulatory surgery such as, shorter visits, influence of
anesthetic agents and drugs, or patient anxiety adds to the
complexity of deciding which methods are best for providing
discharge education in the outpatient setting.

This study revealed that nurses place more importance
on the technical aspects of care such as wound care and
medications than patients who were more concerned with
complications. It is not a question as to who is right, but
how can comprehensive teaching occur when the nurse is
faced with the time constraints of ambulatory surgery?
Teaching needs to be an ongoing process that begins pre-
operatively and continues through recovery. Improved technology such as videos, web sites, and prerecorded telephone messages may provide patients opportunities to review educational materials specific to their procedures. Availability of brochures, medication cards, or written instructions providing directions and telephone numbers may serve to provide patients with minor, yet important information.

Bille (1981) suggests "therapeutic seeding" techniques that plant ideas concerning patient teaching in a patient mind resulting in increased patient involvement. Patients may be given a list of questions related to self-care activities and home activities to promote planning for the post-operative phase of recovery. For example, patients could be encouraged to arrange for car pools if driving is prohibited or completing laundry prior to surgery if lifting limits are required. Individual concerns could then be discussed with the nurse and recommendations made. Availability of these questions may be extremely important for patients undergoing surgery for the first time or those that lack initiative or fear asking "too many questions."

Pre-and post-operative telephone calls provide additional support and follow-up to patients. Using a variety of teaching methods throughout the surgical procedure provides
patients opportunities to plan and consider what effects surgery may have on their lifestyles. Multiple teaching strategies also allow the nurse time to individualize patient teaching using one-on-one teaching strategies to focus on the real needs and concerns of the patient, while knowing that the basic care and safety information related to the surgery has already been provided.

Summary

The growth of outpatient ambulatory surgery centers has challenged the nursing profession to reevaluate traditional patient teaching norms. Collaboration with patients is essential in the development of comprehensive teaching strategies designed to meet outpatient post-operative learning needs. Nurses are encouraged to validate outpatients' learning needs through continued research, education, and clinical practice.
References


APPENDICES
APPENDIX A

Patient Learning Needs Scale by Factors
Questions Grouped According to Factor.

Factor 1: Support and care in the community (10 items)

17 How to get through the "red tape" in the health care system.
31 How to get through the "red tape" to get services at home.
13 How to contact community groups for my health condition.
32 Who to talk to about my concerns about death.
12 How to recognize my feelings towards my illness.
27 Where I can get help in handling my feeling about my illness.
22 How I can avoid stress.
10 How to care for my wound properly.
33 How to prevent my skin from getting sore.
29 How to prevent my skin form getting red.

Factor 2: Medications (8 items)

36 How each medication works.
37 What to do if I have a reaction to a medication.
35 When to stop taking each medication.
04 How to take each medication.
25 Why I need to take each medication.
39 The possible reactions to each medication.
06 When to take each medication.
26 Where I can get my medications.

Factor 3: Treatment and Activities of Living (8 items)

24 What the purposes of my treatment are.
18 What the possible side effects of my treatment are.
02 How to prepare the foods I am to eat.
28 Which foods I can and cannot eat.
30 Which vitamins and supplements I should take.
20 What to do if I cannot sleep properly.
38 What physical activities I cannot do such as lifting.
23 What physical exercise I should be getting.

Factor 4: Complications and symptoms (8 items)

08 How to recognize a complication.
11 What complications might occur from my illness.
03 How to prevent a complication from occurring.
05 What symptoms I may have related to my illness.
21 How to manage the symptoms I may experience.
34 How to manage my pain.
07 How this illness will affect my life.
09 How this illness will affect my future.

Factor 5: Illness-Related Concerns (6 items)

15 How to talk to family/friends about my illness.
40 Where I can get help for family to deal with my illness.
19 What to do if I have trouble with my bowels.
01 What to do if I have trouble urinating.
14 When can I take a bath or shower.
16 How much rest I should be getting.
APPENDIX B

Patients' survey
Informed Consent of Participation

I have been told the reason for this study and I am willing to answer the questions. I know that this study will help nurses teach patients having surgery like mine. I agree to finish and return the study by mail within three days. I do not have to use my name and no one will know my answers.

__________________________________
Patient signature

__________________________________
Date
Thank you for doing this study. Your answers will be used to help nurses know what it was like for you while "getting back to normal." Many women have questions about how to care for themselves at home after surgery. Your thoughts will help others that are going to have the same kind of surgery as you.

You DO NOT have to put your name on this survey. No one will know how you answered the questions.

After you answer all of the questions, mail the survey in the stamped envelope you were given. It should take less than 30 minutes to complete. You may use pen or pencil.
Fill in the blanks.

1. Type of surgery today? ____________

2. Age? (last birthday) ____________

3. Occupation? ____________

Check the correct answer. Check only one.

5. Education

[ ] less than 12\textsuperscript{th} grade
[ ] high school graduate
[ ] GED certificate
[ ] some college
[ ] college degree ____________

(specify type)

5. Marital status

[ ] married
[ ] widow
[ ] single
[ ] divorced

6. Race

[ ] white
[ ] black
[ ] other ____________

7. The day after surgery

[ ] I did everything by myself.
[ ] I did almost everything by myself.
[ ] I did a few things by myself.
[ ] I could not do anything by myself.
Read each of the following statements.

Think about how important each one was for you in caring for yourself at home.

Circle a number in the shaded box that best describes how important each item was to you

1 = not important
2 = slightly important
3 = moderately important
4 = very important
5 = extremely important.

To care for myself at home it is important for me to know:

<table>
<thead>
<tr>
<th></th>
<th>NOT Important</th>
<th>EXTREMELY Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What to do if I have trouble passing urine.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. How to prepare the foods I am to eat.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. How to prevent a problem from occurring.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. How to take each medicine.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. What symptoms I may have because of my illness.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. When to take each medicine.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. How this illness will affect my life.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8. How to know if there is a problem.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. How this illness will affect my future.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10. How to care for my wound.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11. What problems might occur from my illness.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>12. How to identify my feelings toward my illness.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13. How to contact community groups for my health condition.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14. When I can take a bath or a shower.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15. How to talk to family/friends about my illness.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>16. How much rest I should be getting.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17. How to get through the health care system.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>18. What the possible side effects of my treatment are.</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
To care for myself at home it is important for me to know:

19. What to do if I have trouble with my bowels.

20. What to do if I cannot sleep.

21. How to manage the symptoms I may have.

22. How I can avoid stress.

23. What exercise I should be getting.

24. What the reasons for my treatment are.

25. Why I need to take each medicine.

26. Where I can get my medication.

27. Where I can get help in dealing with my feelings about my illness.

28. Which foods I can and cannot eat.

29. How to prevent my skin from getting red.

30. Which vitamins and supplements I should take.

31. How to get through the "red tape" to get aid at home.

32. Who to talk to about my concerns about death.

33. How to prevent my skin from getting sore.

34. How to manage my pain.

35. When to stop taking each medication.

36. How each medication works.

37. What to do if I have a reaction to a medication.

38. What physical activities I cannot do such as lifting.

39. The possible side affects to each medication.

40. Where I can get help for family to deal with my illness.
Pick 5 of the 40 items that are the *most important* to you and list them by number here.

#_______
#_______
#_______
#_______
#_______

Of these five circle the most important.  *Circle only one.*
APPENDIX C

Reading level alterations
## Reading Level Alterations

<table>
<thead>
<tr>
<th>Original</th>
<th>Altered</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 What to do if I have trouble urinating.</td>
<td>Passing urine</td>
</tr>
<tr>
<td>03 How to prevent a complication from occurring.</td>
<td>Problem</td>
</tr>
<tr>
<td>05 What symptoms I may have related to my illness.</td>
<td>Because</td>
</tr>
<tr>
<td>08 How to recognize a complication.</td>
<td>know if there is a problem.</td>
</tr>
<tr>
<td>10 How to care for my wound*</td>
<td>Omitted properly</td>
</tr>
<tr>
<td>11 What complications might occur from my illness.</td>
<td>Problems</td>
</tr>
<tr>
<td>12 How to recognize my feelings toward my illness.</td>
<td>Identify</td>
</tr>
<tr>
<td>17 How to get through the &quot;red tape&quot; in the health care system.</td>
<td>Omitted &quot;red tape in the health care system.</td>
</tr>
<tr>
<td>20 What to do if I cannot sleep properly.</td>
<td>Omitted properly</td>
</tr>
<tr>
<td>21 How to manage the symptoms I may experience.</td>
<td>Have</td>
</tr>
</tbody>
</table>

*(table continues)*
<table>
<thead>
<tr>
<th>Original</th>
<th>Altered</th>
</tr>
</thead>
<tbody>
<tr>
<td>23 What physical exercise I should be getting.</td>
<td>omitted physical</td>
</tr>
<tr>
<td>24 What the purposes of my treatment are.</td>
<td>reasons for</td>
</tr>
<tr>
<td>27 Where I can get help in handling my feelings about my illness.</td>
<td>dealing with</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>31 How to get through the &quot;red tape&quot; to get services at home.</td>
<td>Aid</td>
</tr>
<tr>
<td>39 The possible reactions to each medication.</td>
<td>side affects</td>
</tr>
</tbody>
</table>

*Wound was substituted for feet.*
APPENDIX D

Nurses' survey
Hello, my name is Martha Lisicki and I am requesting your help in gathering data for my thesis. I am investigating the relationship between nurses' and patients' perceptions of discharge learning needs in the outpatient surgery gynecological population.

You were chosen to participate because of your expertise in this field. As you know, with today's changes in health care delivery it is important for us to understand the needs and concerns of our patients. Your cooperation is greatly appreciated.

You do not have to put your name on the survey form. Returning the survey will signify your consent to participate. The survey can be completed in less than 30 minutes.

Thank you,

Martha Lisicki, RN
Fill in the blanks.

1. Age? (last birthday) ____________
2. Total years work experience as RN? ____________
3. Total years work in present position? ____________

Check the correct answer

4. Education
   
   [ ] ADN
   [ ] BSN
   [ ] Masters (specify type)
   [ ] Other ____________

5. Gender
   
   [ ] female
   [ ] male

6. Race
   
   [ ] white
   [ ] black
   [ ] other ____________

7. The day after surgery how much assistance do you think the outpatient surgery gynecological patient needs?
   
   [ ] They do not need assistance.
   [ ] They do almost everything by themselves.
   [ ] They do a few things by themselves.
   [ ] They can not do anything by themselves.
THINK ABOUT PATIENTS THAT HAVE HAD AN OUTPATIENT GYNECOLOGICAL PROCEDURE.

Directions: Circle how important each of the following items is for patients after surgery. Circle only one answer.

1 = not important
2 = slightly important
3 = moderately important
4 = very important
5 = extremely important

To manage their care at home it is important for patients to know:

<table>
<thead>
<tr>
<th>NOT Important</th>
<th>EXTREMELY Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

1. What to do if I have trouble urinating.
2. How to prepare the foods I am to eat.
3. How to prevent a complication from occurring.
4. How to take each medicine.
5. What symptoms I may have related to my illness.
6. When to take each medicine.
7. How this illness will affect my life.
8. How to recognize a complication.
9. How this illness will affect my future.
10. How to care for my wound properly.
11. What complications might occur from my illness.
12. How to recognize my feelings toward my illness.
13. How to contact community groups for my health condition.
14. When I can take a bath or a shower.
15. How to talk to family/friends about my illness.
16. How much rest I should be getting.
17. How to get through the "red tape" in the health care system.
To manage their care at home it is important for patients to know:

<table>
<thead>
<tr>
<th></th>
<th>NOT Important</th>
<th>EXTREMELY Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>1 2 3 4 5</td>
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<td>20.</td>
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<td>21.</td>
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<td>26.</td>
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<td>27.</td>
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<td>32.</td>
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<td>33.</td>
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<td>36.</td>
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<td>37.</td>
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<td>38.</td>
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<td>39.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>40.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
Pick 5 of the 40 items that are the *most important* for the patient. List them by number here.

# ______

# ______

# ______

# ______

# ______

# ______.

Of the 5 items you chose, circle the most important one.