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Preoperative Education Needs in Ear, Nose, & Throat Clinic: A Patient Perspective

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COLLEGE OF EDUCATION

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2014

Abstract

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Abstract

A medical center specializing in ear, nose, and throat (ENT) services noted an increase in the number of postoperative ENT complications compared to the national average. The purpose of this mixed-methods project study was to examine ENT patients' preoperative patient education (PPE) needs regarding postoperative care. Grounded in Knowles's model of learning, core adult learning principles were applied as guidelines in facilitating patients' PPE learning. Data were collected from 58 ENT patients who were selected using a convenience sampling method and who responded to a PPE survey using a 5-point Likert scale and open-ended questions. Quantitative data were analyzed using descriptive statistics. Qualitative data were analyzed using content analysis for emergent themes. The quantitative findings included patients' perceived needs for preoperative and postoperative information regarding ENT care and surgery complications. The qualitative findings included patients' perceptions of PPE in ENT and recommendations for how to use PPE before and after surgery. Implications for positive social change include an awareness of patients' perceptions of PPE needs in ENT by hospital administrators, doctors, and nurses. A better understanding of PPE by patients could result in lower levels of postoperative complications in ENT.

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Dedication

I dedicate this project study to all the veteran patients who have served and fought for the freedom of this great nation.

Acknowledgments

I would like to acknowledge the love and understanding of my wife, Anna Ramos, RN, and my children, Jordan, Lauren, and Chealsie, in the pursuit of completing my doctorate in education. Also, I would like to recognize Reena Dhanda-Patil, MD; Kathy Wright, PhD; Barb Dalton, RN, MSN; Catherine Constance; Engr. Jose Alejandro F. Crisostomo; and Jeff Griffith, RN for their valuable feedback and support in achieving the goals of this research study.

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Section 1: The Problem

Introduction

The Veterans Administration Surgical Quality Improvement Project's (VASQIP's) nurse at the Cincinnati Veterans Administration Medical Center (CVAMC) recounted variations in the observed versus expected (O/E) morbidity ratios report from fiscal year (FY) 2009 to 2012 (J. Griffith, personal communication, August 18, 2014). The problem I identified at the CVAMC ear, nose, and throat (ENT) surgery service was the unforeseen and significant increase in the O/E morbidity ratios specifically for FY 2011. Given the magnitude of this problem, the CVAMC chief of ENT service and quality management nurse of surgery service posited that an increasing trend in the O/E morbidity ratios indicated a need for intervention (R. Dhanda and B. Dalton, personal communication, July 28, 2011).

Consistent with the VASQIP's index of performance standards, an O/E morbidity ratio greater than 1 is an indication of a significant number of adverse events, and an O/E morbidity ratio less than 1 is an indication of a smaller number of adverse events (Cohen, Bilimoria, Ko, & Hall, 2009). A high O/E morbidity ratio is cause for concern because the ratio suggests poor surgical outcomes (Khuri et al., 2008). Therefore, the higher the O/E morbidity ratio, the higher the number of patients with postoperative complications (Henderson & Daley, 2009).

Furthermore, the costs of hospitalization can substantially increase following postoperative complications (Vaughan-Sarrazin et al., 2010). To illustrate, Vaughan-Sarrazin, Bayman, and Cullen (2011) completed a comprehensive cost analysis study on

reducing surgical complications and concluded that a 15% decrease in the complication rate would save more than $100,000 in one veterans hospital alone, and the projected savings are potentially $8.8 million per year. Considering this amount, the reduction in the hospitals' complication rates even by a small fraction would increase savings. The incidence of hospital morbidities is important because of its impact on patients' quality of care and escalating hospital expenses associated with postoperative complications. I define the nature and scope of the project study problem and its impact in the next section.

Definition of the Problem

Data from FY 2009 – FY 2011 at the CVAMC ENT service showed a marked increase in the ratio of O/E adverse events. Although the ENT service revealed gradual progress on the FY 2012 report, the data continued to evidence a substantial number of adverse events. Conversely, the FY 2013 report demonstrated improvement. Based on these inconsistencies, the data suggest a threat to sustainability on reducing postoperative adverse events. Evidence from data also supports the need to identify areas of substandard performance and potential causes of postoperative complications among the patient population. Hence, I reviewed different possible factors affecting morbidity rates in the ENT service. Such efforts are essential to appreciate the maintenance of positive curves in overall health sustainability.

The Local Setting - CVAMC

The CVAMC in Ohio was the setting of this study. The CVAMC is the only VA healthcare system in Ohio that provides an ENT surgery service (United States

Department of Veteran Affairs [USDVA], n.d.). The CVAMC ENT service offers different head and neck surgeries including thyroidectomy, neck dissection, cochlear implant, septorhinoplasty, septoplasty, tonsillectomy, tympanomastoidectomy, panendoscopy, parotidectomy, and tracheostomy (R. Dhanda, personal communication, July 18, 2011).

I chose the CVAMC ENT site because this facility had a statistically significant O/E morbidity ratio in ENT service for FY 2011. Although the ENT service has recently demonstrated reduction in their adverse surgical outcomes, the variability in the number of adverse events presents the question of stability and sustainability. According to Neumayer (2009), a significant O/E ratio is important because it indicates two things:

- The ENT service at the CVAMC had substantial incidences of adverse postoperative outcomes compared to the national average.
- The ENT service at the CVAMC had a high outlier status.

In the next section, the relationship between the project study problems and CVAMC is presented.

Relationship of the Problem at the CVAMC

One problem associated with postoperative complications is extending patients' length of stay in the hospital. Baehring and McCorkle (2012) showed that postoperative complications in head and neck surgery result in patients' delay in treatment, possible life-threatening problems, and an increase in medical costs. Berenguer, Ochsner, Lord, and Senkowski (2010) concluded that adverse postoperative events complicate the quality of patient care and increase the costs of hospitalization.

Another problem emphasized by the chief of nursing service at CVAMC is the high level of nursing workload required for patients who have postoperative complications (B. Ackerson, personal communication, July 18, 2011). Hinno, Partanen, and Vehvilainen-Julkunen (2011) and Lin (2013) concluded that high level of patient acuity may affect the quality of patient care. Bernard, Hunter, and Moore (2012) added that when patients display symptoms of complications, those symptoms warrant a higher demand of nursing care.

From the examples of increased days of hospitalization and high level of nursing workload, several studies indicated a direct link between postoperative complications and quality of patient care (Mark & Harless, 2009; Visser et al., 2012). Other studies also implied a direct relationship between postoperative complications and excess costs of hospitalization (Itani, 2009; McCullough, Weber, Leong, & Sharma, 2013; Rusu, Rusu, & Bulicrea, 2013; Zoucas, & Lydrup, 2014). The problem of postoperative complications led Vaughan-Sarrain et al. (2011) to complete a comprehensive analysis of costs in treating patients with complications and showed that patients with respiratory complications can cost one VA hospital up to $62,726. In addition, management of patients with other expensive treatments related to systemic sepsis and acute renal failure cost one veterans hospital more than $90,000.

In retrospect, Vaughan-Sarrain et al. (2011) concluded that decreasing incidence of morbidities will improve the quality of patient care. The decrease can also offer the hospital significant cost savings. Therefore, the advantages of enhancing patient care and reducing hospital costs will enhance outcomes at the CVAMC. However, despite

educational efforts in the ENT service, the avoidable postoperative complications remain evident in the practice; hence, a gap in practice exists, which is explored in the next section.

Gap in Practice

The Endocrine Society (n.d.) defined a professional *practice gap* as "the difference between the current state of knowledge, skills, competence, practice, performance or patient outcomes and the ideal or desirable state" (para 2). The American Association of Neurological Surgeons (n.d.) added, "When there is a gap between what the professional is doing or accomplishing compared to what is achievable on the basis of current professional knowledge, there is a professional practice gap" (para 1). Realizing the problem of postoperative adverse events in the patient population, a thorough review of the present preoperative patient education practice as well as the ways in which the learning experiences of patients could be improved regarding avoidable postoperative complications is presented.

In the current practice of providing preoperative patient education, the providers at the Department of Veteran Affairs (DVA) primarily use the iMEDConsent, which is a system-wide computer-based automated informed consent tool (Isgett-Lynn, 2011). According to VA memorandum no. 11-43 (2013), the iMEDConsent process serves as a framework within which the physicians provide the patient education regarding clinical treatments and procedures.

As such, the iMEDConsent provides patients with information needed to make rational decisions about their care (Hall et al., 2012). During the process, the attending

surgeons and/or the ENT residents educate the patients on the nature and purpose of the treatment, risks and benefits, potential complications, alternative therapies, and possible consequences when patients decline the proposed procedure. Integrated into the computerized patient record system (CPRS), the iMEDConsent presents an improved documentation procedure (Fink et al., 2010).

After the ENT surgeon addresses and answers the patient's questions, the patient will sign the iMEDConsent using a digital signature pad. The electronic signature indicates that the patient consented to treatment and expressed understanding. The document can be viewed by providers and patients in CPRS. A copy may be provided to patients, if so desired. Signing of the consent may take place either prior to or on the day of surgery.

In spite of studies that showed effectiveness of the iMEDConsent in educating patients preoperatively (Isgett-Lynn, 2011), unnecessary postoperative complications remain evident in practice. Fink et al. (2010) added that the clinical impact of iMEDConsent remains unknown. Falagas, Korbila, Giannopoulou, Kondilis, and Peppas (2009) and Goldberger, Kruse, Kadish, Passman, and Bergner (2011) argued that informed consent is suboptimal and should not be used exclusively as the principal method of teaching patients about their proposed surgical procedures. Thus, a gap exists between evidence and practice.

Given this critical void, I was led to review ways to help reduce avoidable postoperative complications. As supported by the findings of Pritchard (2011), educational efforts are vital because information prepares patients on what to expect

before and after surgery. To possibly close this gap in practice, I focused my efforts on evaluating and understanding the patients' perspectives regarding their preoperative education needs in the ENT clinic. The rationale for this project study provides evidence of the problem and its impact at the local level, and I discuss it in the next section.

Rationale

Evidence of the Problem at the Local Level and From the Professional Literature

Previous studies explored the concept that providing patients with adequate information regarding hospital admission processes, risks and benefits of surgery, and recovery time can improve patient outcomes (Foss, 2011; Hinami et al., 2014). Aasa, Hovback, and Bertero (2012) and Foss (2011) examined the relevance of patient education, and their studies showed that providing patients with preoperative information is helpful. However, despite efforts of the CVAMC ENT staff teaching surgical patients about perioperative expectations, the postoperative complications rate was relatively high in FY 2011. Certain staff members in surgery service also expressed their concerns regarding the problem of sustainability as well as stability on the number of postoperative adverse events. For example, the quality management (QM) nurse conveyed the need to investigate the identification of and relationship of causative factors to improve surgical outcomes of patients (B. Dalton, personal communication, July 28, 2011). Moreover, the VASQIP nurse concurred with the need for quality improvement (QI) activities (J. Griffith, personal communication, July 28, 2011).

The section chief of ENT supported plans for making improvements in patient care and efforts in managing the hospitals' resources (R. Dhanda, personal

communication, July 28, 2011). For example, certain ENT patients including participants in the head and neck cancer support group voiced their opinions regarding the need for preoperative patient education on ways to prevent postoperative complications (K. Groves, personal communication, August 6, 2011).

In view of the relevance of teaching patients regarding perioperative expectations, the gap in practice related to the current patient education process in ENT clinic needs to be reviewed. The chief purpose of addressing the problem is to sustain as well as to decrease the number of postoperative adverse events in the ENT service. Appropriate project study terminology definitions pertinent in this project study are outlined in the next section.

Definitions

Patient education: Polikandrioti and Ntokou (2011) defined *patient education* as "the process of acquiring knowledge and skills that can lead to changes in human behavior, necessary for the maintenance or improvement of health" (p. 17). Similarly, the Veterans Health Administration (VHA) handbook 1120.03 defined *patient health education* "as the process of assisting individuals, acting separately or collectively, to make informed decisions about matters affecting their personal health and that of others" (p. 2). If patients absorbed and used patient education as designed, these definitions imply that information empowers patients. From this viewpoint, Reid et al. (2010) argued that information promotes better understanding of the proposed procedure including the implications of surgery. Information enables patients to make decisions regarding their own care. In support of this literature, Birmingham (2009); Eloy, Svider, and Setzen

(2014); Foss (2011); and Johansson, Katajisto, and Salantera (2010) asserted that well-informed patients are likely to reduce their risk factors and improve their surgical outcomes. Stonecypher (2009), however, argued that patient teaching may be ineffective because of many patients' low health literacy levels. This finding is consistent with the observation of Braido et al. (2011) that education materials should be written at lower than average reading levels. According to the education coordinator at the CVAMC, the patient education materials had to be written at a sixth to eighth grade reading level (J. Seltzer, personal communication, July 18, 2011). This reading level is imperative because patients become compliant with their treatment plans if they can comprehend the health information materials.

Patient information need: According to Ormandy (2009), *patient information need* is "the recognition that their knowledge is inadequate to satisfy a goal, within the context/situation that they find themselves at a specific point in the time" (p. 99). This definition is relevant to this study as it suggests that patient information promotes positive surgical outcomes, hence, less adverse postoperative events.

Postoperative complication: For the purpose of this paper, *postoperative complication* is defined as "any unanticipated adverse event requiring intervention or prolonging length of stay" (Patel et al., 2009, p. 146).

Significance

The VASQIP's rolling 12-month report displays the performance evaluation of each hospital (VA National Surgery Office Quarterly Report, 2012a). Romano et al. (2009) considered VASQIP's report a robust approach in surgical services because it led

to marked improvements in surgical quality. For purposes of comparing the adverse outcomes with the national data average, the CVAMC was the high outlier in FY 2011 (VASQIP nurse, personal communication, July 28, 2011). In fact, the CVAMC ENT service displayed an ascending trend of patients who had postoperative complications in FY 2011. This retrospective finding was the core problem of this project study.

To examine the different postoperative complications that may occur at CVAMC, I performed an in-depth chart review of ENT surgery cases between April 01, 2010 and March 31, 2011. I found that a complication of urinary tract infection (UTI) was the most common of the postoperative occurrences in ENT patients.

A UTI is a common healthcare-associated infection (Bernard et al., 2012; Dumont & Wakerman, 2010). The majority of the cases associated with UTI are due to use of an indwelling urinary catheter in hospitalized patients (Trautner, 2010). This complication is also known as catheter-associated urinary tract infection (CAUTI; Mara et al., 2009). Rothfield and Stickley (2010) found that CAUTI is a preventable surgical complication.

Minimizing duration or limiting use of catheter only when indicated can prevent infectious complications and deaths (Bruminhent et al., 2010). According to Gould (2009), the Center for Disease Control (CDC) estimated 13,000 deaths annually attributed from CAUTI complication, and between $0.4 and $0.5 billion spent per year nationally to treat this complication. Given such data and figures, the CDC suggested that patient education is a valuable effort to prevent complications postoperatively.

Complications affect total costs of hospitalization including increased length of stay in the hospital, nursing workload, supplemental expense on medications and treatments, and possible additional surgeries (Bosma, Veen, Jongh, & Roukema, 2011). These factors lead to the purpose of this project study. Identifying the problem related to postoperative complications will be meaningful and useful for the ENT service at the CVAMC because it will help sustain a relatively low number of adverse events. Subsequently, sustaining the O/E morbidity ratios will represent an optimal standard of surgical care.

Project Study Guiding Question

Patient education has been extensively reviewed in recent publications on advantages, outcomes, and significance (Foss, 2011; Friedman, Cosby, Boyko, Hatton-Bauer, & Turnbull, 2010; Johansson, Katajisto, & Salantera, 2010). In spite of numerous research studies and evidenced-based practice regarding relevance of patient education (Yiu et al., 2010), there is a lack of studies focus on the information needs of ENT surgical patients.

Alkubati, Al-Zaru, Khater, and Ammouri (2012) suggested that patients' need for information is central to ensuring quality care. Davis et al. (2014) reported that an overview of the surgery and recovery process can prepare patients. Given the absence of a comprehensive patient centered education process in the ENT clinic and its documented value of teaching patients perioperative expectations, the purpose of this project study was to examine the patients' perceived information needs regarding surgery and

postoperative care. Hence, the research question was, "What are the patients' perceived information needs in the ENT clinic prior to surgery?"

The highlight of the research question was the perceived information needs of patients on the preoperative information. To help answer the research question, I used Malcolm Knowles's learning assumptions as the doctrinal framework of this project study. In the succeeding sections, I describe the supporters and critics of Knowles regarding his views on adult learning and illustrate the relevance of Knowles's work in teaching adult patients.

Review of Literature Addressing the Problem

Supporters of Malcolm Knowles's Theoretical Framework

Knowles (1984) popularized the term known as *andragogy*, which is "the art and science of helping adults learn" (p. 52). The concept of andragogy became popular in Europe in the 1830s (Knowles et al., 2011). Andragogy did not gain recognition and acceptance in the United States until the beginning of 1960s (Knowles, 1984). Merriam et al. (2007) supported the value of Knowles's andragogical principles because they contribute to the understanding of how adults learn. Additionally, Chan (2010) found that andragogy is not only applicable in education and training of adults but also beneficial in the field of health care. Further, Bastable (2008) concurred that andragogy is a "useful framework in guiding instruction for patient teaching" (p. 172). For this reason, I chose Knowles's model of andragogy as a guide in teaching patients.

Researchers such as Brookfield (1986), Hartree (1984), Davenport and Davenport (1985), Elias (1979), and Rachal (2002) have debated, examined, and analyzed

Knowles's andragogical model (Taylor & Kroth, 2009). Critics of the relevance of andragogy are also instrumental in this project study. I discuss their insights with regard to the andragogical model in the subsequent section.

The andragogical approach includes the following set of assumptions: (a) the need to know, (b) the learner's self-concept, (c) the role of the learner's experience, (d) readiness to learn, (e) orientation to learning, and (f) motivation (Knowles, Holton, & Swanson, 2011). This set of assumptions is helpful to people who work with adult learners because it describes their unique characteristics (Merriam et al., 2007). Wlodkowski (2008) found these characteristics crucial to understanding the adults' behaviors, styles, and attitudes toward learning. In fact, Arogundade (2011) argued that a good understanding of adult learning principles is essential in teaching adults.

Knowles's adult learning principles are also helpful in teaching adult patients (Chan, 2010; Knighton, 2009). Goudreau et al. (2008) found that educating patients has numerous benefits including improvement in patient outcomes. This project study underscores Knowles's discussion of how the basic principles or a set of assumptions on adult learning are valuable in adult teaching practices.

The first of Knowles's six assumptions include the need to know (Knowles, 1984). Knowles's assumption refers to adults' inquisitive behavior before engaging in any activity (Knowles et al., 2011). Their behavior is particularly important because adults need to know the value of learning before engaging in any activity (Ozel & Karabacak, 2012). Knowles (1984) clearly shared the same values. Incidentally, Uzun, Ucuzal, and Inan (2011) found that adults typically want to know what and why they are

learning. Patterson (2009) provided a good example of this adult behavior when learning about wound infection.

Infection is common complication after an invasive surgical procedure (Koboyashi, 2008). According to Patterson (2009), adult patients demonstrate desire to learn by asking information on what signs and symptoms to monitor for infection or how to avoid potential complications. From this perspective, Knowles's position that adults need to know why they need to learn is a relevant assumption. For example, it is essential for health educators to explain what critical information patients need to know about surgery to improve patient outcomes (Chen, Lai, Liao, Chang, & Lin, 2009, Soever et al., 2010). This position supports Knowles's (1984) assertion that adults are more receptive to learning when provided with explanations.

The second assumption is the learner's concept (Knowles, 1984). This assumption considers adults as unique learners who prefer to be self-directed (Knowles et al., 2011). LeCroy (2009) added that self-directed learners are responsible, motivated, and mature individuals who are capable of learning. This assumption may manifest itself in an activity such as adults learning how to treat a postsurgical wound, which Gould (2012) stressed as an important example of patients as self-directed learners. Additionally, Gould noted that when patients learn a skill, they feel empowered; therefore, patients become self-directed through the process of their own care. Uzun et al. (2011) showed that when adult patients learn preventative methods such as learning early signs and symptoms to monitor for infection, they can avoid unplanned readmissions to the hospital or unnecessary treatments in the ER.

From these examples, Knowles's position on self-directed learning is important as it helps health educators recognize that adult patients can be engaged as partners in their prescribed treatments. Moreover, self-directedness provides patients a better sense of control in their care (Knighton, 2009; McCarley, 2009).

The third assumption is the role of the learners' experience (Knowles, 1984). This assumption suggests that as adults mature, they gain a wealth of experiences (Knowles et al., 2011). Full of life experiences, the adults share their knowledge with the group, and their contributions become a valuable source of information (Taylor & Kroth, 2009). Additionally, Wlodkowski (2008) considered sharing of experiences among patients remarkably useful because adults' experiences offer a resource for learning. This assumption is particularly useful because patients share their surgical experiences with one another and gain insight and shared knowledge. Of note, these experiences are beneficial for health care providers and educators in planning the surgical care of patients including ways to prevent avoidable complications (McInnes et al., 2008; Tagney, 2009). Baumgartner (2011) also examined adult learning and discovered that patients teach and learn from each other when dealing with their long term illnesses. Baumgartner reported that adults treat their past life experiences as a significant factor of their new and future learning endeavors.

The fourth assumption is adults' readiness to learn (Knowles, 1984). This assumption recognizes "adults become ready to learn those things they need to know . . . in order to cope effectively with real-life situations" (Knowles, 1984, p. 58). This assumption is associated with adults' desire to learn relevant issues that will directly

impact their lives. McInnes et al. (2008) found that readiness to learn is an important behavior in adult learning.

For example, Ozel and Karabacak (2012) demonstrated that patient education is essential in identifying early signs and symptoms of complications. The implications of their study showed that teaching patients before discharge from the hospital is crucial for health care providers in preventing patients' unplanned readmissions and avoidable postoperative complications. From this point of view, it is important to assess patients' readiness to learn in order to achieve desired patient educational endeavors (Bastable, 2008). Patient education is productive when patients are willing and ready to learn.

The fifth assumption is the patient's orientation to learning (Knowles, 1984). This assumption suggests that adults are "problem centered" or "task oriented" (Knowles et al., 2011). Chan (2010) referred this assumption as a "patient centered" approach because adults learn best when educators present real-life examples (Knowles et al., 2011). Merriam et al. (2007) added that adults prefer learning opportunities that will help them solve or deal with their problems. For example, according to Buntzel et al. (2012), compromised nutritional status is a potential health risk for patients before major head and neck surgeries. Felekis et al. (2010) and Ackerberg (2011) supported this patient safety concern. Both authors concluded that adequate nutrition reduces hospital morbidities. From this example, teaching patients about the various complications associated with poor nutrition before surgery is helpful for the patient. Patient education should focus on how patients can improve nutritional status to prevent postoperative morbidity and mortality (Andreoli, De Lorenzo, Cadeddu, Iacopino, & Grande, 2011).

This adult learning characteristic is relevant because it explains why learning activities should be structured around real-life situations.

Patient motivation is Knowles's sixth construct (Knowles, 1984). This assumption focuses on adults' internal and external motivators (Knowles et al., 2011). According to Taylor and Kroth (2009); however, internal forces are often more significant motivators. An example of internal motivators includes a patients' desire for quality of life (Knowles et al.). This assumption is significant because it explains what influences adults to learn. Gom (2009) stated, "Learning without understanding the effect of motivation is a recipe for disaster" (p. 18). Wlodkowski (2011) agreed that it is insightful for educators to understand what motivates adult learning.

Misra et al. (2012) revealed that motivation to learn between genders is different. This finding is noteworthy because men respond to patient education differently than women. For example, men are hesitant to discuss their diagnosis or surgical treatments, unlike women who are more social (Sach & Whynes, 2009). Orth-Gomer (2012) reported that men are less motivated in discussing their symptoms or postoperative complications than women; however, both studies indicated that there is a strong clinical need to examine what motivates men and women in learning. Motivational factors are important because awareness of risk factors or treatments can reduce morbidity and mortality (McQueen, Vernon, Meissner, & Rakowski, 2008).

In essence, I recognized that Knowles's set of principles fits the theoretical framework of my study. I selected Knowles's learning assumptions because they are valuable in facilitating adults' or patients' learning. Along these same lines, Henschke

(2011) concurred that the future of andragogy suggests improvements in adult education and learning. Nonetheless, there are several theorists who questioned the validity of Knowles's theory of adult learning (Taylor & Kroth, 2009). Despite the critiques in andragogy, Holton III et al. (2009) contended that the influence of Knowles's views on adult learning remains. These critiques are important because they provide an understanding about the weak points of Knowles's formulation of adult learning principles. I explore some of those critiques in the subsequent section.

Critiques of Malcolm Knowles's Adult Learning Theory

For several generations, educational theorists have been searching for a unified theory in adult learning (Brookfield, 1986). As previously indicated, one groundbreaking and influential theory was the concept introduced by Knowles known as andragogy (Merriam et al., 2007). Although there are several supporters of andragogy, there are also theorists who have critiqued Knowles's theory of adult learning (Brookfield, 1986; Cross, 1981; Knowles et al., 2011).

The purpose of discussing Knowles's critics was crucial for this project to satisfy both necessary and sufficient conditions, as I reviewed the limitations of his work. Examining Knowles's critics presented valuable insights from different adult educators. These insights are relevant because they provided deeper and more substantial interpretations of the andragogical model.

This comprehensive review of Knowles's work included the conflicting philosophical premises, debates, dialogues, and critical analysis of various adult educators. Much of the controversies stem from whether andragogy is a theory, set of

guidelines, set of principles, technique, a set of elements of good practice, a set of adult teaching behaviors, a model of teaching, or a philosophically based prescriptive concept (Brookfield, 1986; Cross, 1981; Knowles, 1984). Despite many years of critique, the controversies surrounding Knowles's adult learning principles have endured based on several problems (Knowles et al., 2011).

For example, Hartree (1984) questioned the conceptual clarity of Knowles's model of adult learning. Hartree's views underlying Knowles's learning assumptions have been cited in many articles. Knowles posited that the method of learning between children and adults varied considerably (Knowles et al., 2011). This fundamental assumption between children and adults remains contentious. Knowles (1984) separated pedagogy, which he referred to as "the art and science of teaching children" (p. 52), from andragogy. This statement implies that children are dependent on their teachers or facilitators for learning. The pedagogical model gives teachers or facilitators the full responsibility for making decisions in the students' learning experiences in class. Teacher-directed education promotes learners to take on a submissive role in the learning process.

Geared toward adults, the andragogical model encourages students to take responsibility for their own learning (Knowles, 1984). Merriam et al. (2007) added that adults perform best in an autonomous learning environment. From this standpoint, Knowles asserted that there are distinct learning practices between adults and children; hence, they require different methods of teaching. McGrath (2009), however, refuted this claim and suggested that pedagogy can be associated with andragogy. As Hartree (1984)

debated, Knowles displayed a considerable degree of ambiguity and lack of precision in differentiating children from adult learning. Nonetheless, the position of Knowles's opponents, both in andragogy and pedagogy, has significant relevance to the adult educator, such as in the area of patient teaching.

Teaching families and caregivers plays a pivotal role in the successful health outcomes of patients (Sheets & Mahoney-Gleason, 2010). According to Fruhauf and Orel (2008), many young and adult caregivers participate in the care of their sick or chronically ill family members. Burns, LeBlanc, Abenethy, and Currow (2010) found that some caregivers were as young as 8 years old. Viola, Arno, Siskowski, Cohen, and Gusmano (2012) emphasized the importance of including caregivers, both children and adults, in discharge and home care planning. The young caregivers should not be excluded from participating in patient education because of their pedagogical strategy of learning. This concept is important because, contrary to Knowles's arguments, some adults are dependent on their teachers or facilitators for learning, and some children are independent self-learners. While Knowles (1984) contended that adults learn differently from children, McGrath (2009) claimed that they have similarities. If there is no clear distinction between adult and child learning characteristics, this concept makes the acceptance of andragogy as a unified adult learning theory.

A closer scrutiny of Knowles's position on andragogy offers evidence of even more questions and uncertainties on his proposals related to adult learning. In another instance, Hartree (1984) argued with Knowles's postulates regarding adults as self-directed learners. While this statement may be true, Hartree (1984) rejected this

assumption on the basis that not all adult learners are self-directed. Simply put, some adults prefer a familiar pedagogical style of classroom learning and teaching. Scholars such as Brookfield, one of the leading proponents of self-directed learning, disagreed with Knowles's notion that all adults are natural self-directed learners (Knowles et al., 2011). Knowles (1975) defined adults' *self-directed learning* as "a process in which individuals take the initiative, with or without the help of others, in diagnosing their learning needs, formulating learning goals, identifying human and material resources, choosing and implementing appropriate learning strategies, and evaluating learning outcomes" (p. 18). Contrary to Knowles's position, Brookfield (1986) argued that self-directedness is not an innate characteristic of adults. In fact, Brookfield stressed that age is neither a defining characteristic nor a measurement of self-directed learning.

From this perspective, there is some confusion to Knowles's claims that as dependent children get older, they automatically transform and become independent self-directed adult learners. This claim implies that there are no elements of self-directedness in children. Conversely, Nor and Saeednia (2008) found that the qualities of self-directed learning are consistent in both children and adults and concluded that self-directed behaviors are not limited solely to adult learners. Brookfield (1986) contested Knowles's philosophical foundation as a theory of learning because it lacks empirical data.

Following the early reservations voiced by Hartree (1984), Davenport and Davenport (1985) argued against Knowles's concept of andragogy and agreed with the findings of Houle (1972), London and Thornton (1973), and Elias (1979) that the learning processes of both children and adults are fundamentally the same.

Knowles (1984), however, posited that there are distinctive differences in the learning style and behavior of children and adults. In addition, Knowles et al. (2011) claimed that the teaching practices in the traditional pedagogical approach are inappropriate in the andragogical methodology. Again, this position of Knowles's appears to be ambiguous as it lacks scientific evidence.

As indicated earlier, there are many young children who provide care to physically or mentally ill family members. In fact, Simon and Slatcher (2011) found that 82% of young caregivers provide emotional support. Surprisingly, about 48% of young caregivers perform general nursing care including giving medications, changing dressings of their wounds, and assisting with their activities of daily living. Considering these figures, health care professionals should include the young caregivers during the early stages of planning and discharge care of their family members.

Although negative consequences on young caregivers have been documented (Charles, Stainton, & Marshall, 2009; Fruhauf & Orel, 2008), recent findings carried out by Harstone, Bergen, and Sweetgrass (2010) and Williams, Ayres, Specht, Sparbel, and Klimek (2009) support positive outcomes of young children caring for family members with acute or chronic illness or disability.

The positive outcomes for young caregivers, according to Harstone et al. (2010), include fostering self-reliance and self-directedness, developing a sense of caring and compassionate attitude to others, improving positive communication skills, and enhancing coping skills. From this standpoint, if young caregivers can assume adult responsibilities, Knowles's fundamental assumption on self-concept is arguable and

confusing. Knowles's assumption about adult learners is "as a person matures his self-concept moves from one of being a dependent personality toward one of being a self-directed human being" (Knowles, 1975, p. 45). Erikson (1978) and Piaget (1928), however, stand in opposition to Knowles's concept because they both observed self-directedness in children's learning. Such observation is of fundamental importance because it challenges Knowles's appeal that adults are unique to children in terms of learning.

In his study, Knowles formed an inadequate basis of differentiating teaching adults and teaching children. Building on the theories of Erikson, the psychoanalyst famous for his eight stages of psychosocial development (Thomas, 2008), Knowles postulated that children assert behaviors of autonomy and/or independence beginning at the age of two (Erikson, 1978). Piaget, renowned for his research on children's' cognitive development, posited that children exhibit the ability to think abstractly in the formal operational stage (Arrington, 2008; Piaget, 1928). Both Erikson and Piaget suggested convincing theories that children, at certain stages of their development, are capable of independently acquiring information or are competent in problem solving.

Similar to Erikson and Piaget's positions on children's learning, Elias (1979) supported their arguments. Elias stated, "Teaching adults is essentially the same as teaching children" (p. 252). Cited throughout numerous journals, Elias's critique provided a different perspective on Knowles's conception of adult learning assumptions. Elias argued Knowles's assumption on adult's self-concept was acceptable yet arguable. Elias contended that children learn independence much earlier before reaching adulthood,

but also failed to see the quality of experience as a relevant factor differentiating pedagogy from andragogy.

Further, Elias explored Knowles's assumption on adults' readiness to learn. Elias considered this assumption inadequate and unconvincing, along with other assumptions made by Knowles. Elias (1979) disagreed with Knowles's classification of children as future centered and adults as present centered (Knowles, 1984). Although Elias considered this assumption valid in some respects, he found Knowles's arguments ambiguous. Moreover, Elias had reservations with Knowles's argument that children transform from being subject-centered to problem-centered learners (Knowles, 1984). Another concern Elias presented was that Knowles's restriction of problem-centered education to adults only. Elias was critical of Knowles's reasoning complex regarding adults' and children's orientation to learning.

Another argument offered by Elias was that the differences between adults and children rest in their physical and social characteristics, but there are no basic differences separating them in their fundamental method of learning. Convinced that the years of debates over the conflicting educational theories of pedagogy and andragogy was a "misguided attempt to enhance the status for the field of education" (p. 254), Elias thought that it was, however, an admirable and helpful presentation of two different approaches in learning between children and adults. Nonetheless, based on Elias's arguments, Knowles failed to present a robust case for a valid unified theory of learning in a systematic way.

Another critique of Knowles's theory came from Rachal (2002), who was also cited in many articles regarding Knowles's pressing views on volunteerism. According to Knowles (1984), one characteristic of adult learners included voluntary participation in their learning experiences. This description, however, falls short on those less motivated patients or those who are not ready to learn because of their limited physical, emotional, social, or mental abilities (Pederson & Zachariae, 2009). Rager (2009) further described this limitation as similar to fear. A patient's fear may restrain them from learning or processing information.

In this view, patients' emotions are critical in the adult learning process. Barriers such as fear or other strains on patients' emotional, mental, and physical health may prevent patients from voluntary participation in the learning process.

These strains on patients' emotional and physical health that inhibit the learning process are clearly indicated in head and cancer surgical cases. The diagnosis of cancer often causes emotional, mental, and physical stress (Horney et al., 2010). According to Rigdon (2010), the stress of dealing with the illness, learning complicated medical treatments, and dealing with possible surgical complications can present barriers to learning. In most cases, patients diagnosed with cancer reported mixed emotions including feelings of anxiety, distress, fear, anger, and denial (Cheng, Lo, Chan, Kwan, & Woo, 2010). These maladaptive behaviors often resort to delay in medical and/or surgical treatments as patients disengage from learning activities (Siemerink, Jaspers, Plukker, Mulder, & Hospers, 2011). Hence, the imbalance on patients' emotional and

physical well-being presents a gray area in Knowles's concept of andragogy that adults are generally self-directed, ready to learn, problem-oriented, and motivated learners.

Other examples of barriers to learning are cognitive and sensory deficits. One example of this impairment that often affects patients' cognitive performance is postoperative delirium (Kat et al., 2008). Acute episodes of delirium prevent patients from voluntarily participating in learning activities. Kat et al. (2008) posited that postoperative delirium contributes to increased morbidity and mortality, and prolonged hospitalization. Baxter and Bradley (2008) revealed that patients with cognitive and sensory deficits may not report their symptoms properly, often resulting in an absent or delay in treatment. Sullivan and Hussain (2008) suggested that patients' lack of cognitive skills limit compliance with their recommended treatments including surgery. These findings are in line with Rachal's (2002) arguments that Knowles failed to differentiate adult learners from those who are incapable of engaging in learning activities because of cognitive disorders.

Another barrier to adult learning is low health literacy levels. According to the Institute of Medicine (IOM, 2008), *limited health literacy* is "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (p. 31). Health literacy has become a concern in the healthcare profession, and it is also of considerable importance for the education system (IOM, 2008). Such concern could stem from the fact that the National Assessment of Adult Literacy (NAAL) reported that approximately 12% to 14% adults or 27 to 31 million people in the United States were below basic readers

(Kruidenier, MacArthur, & Wrigley, 2010). Edwards, Wood, Davies, and Edwards (2012) and Roett (2012) found that these adults with low literacy are more susceptible to poor health outcomes. Adults with inadequate health literacy may not voluntarily participate in learning activities because of their physical and/or mental limitations. Critics such as Cross (1981) commented that Knowles's views are problematic because they focused on idealized situations. Further, Rachal (2004) also supported this premise and added that Knowles's andragogy "apply only in those situations . . . deemed appropriate" (p. 224).

Nonetheless, despite biases, critiques, and surrounding controversies, Knowles's foundational thinking on adult learning endures in the field of adult education (Holton III, Wilson, & Bates, 2009; Zamir & The David Yellin Academic College of Education, Israel, 2010). In fact, some of Knowles's supporters including Chan (2010) and Cleary and Wozniak (2013) ascertained that educators often use Knowles's concept of andragogy as a guideline or model of adult learning.

For this project study, I encountered many educational theorists who disagreed with Knowles's model of learning (Cooke, 2010). I also discovered that Knowles has provided educators a better sense of understanding of how adults learn (Wlodkowski, 2008). Of similar importance, I recognized the significance of understanding patients as adult learners. This realization led to the social change I am advocating in the ENT clinic at the CVAMC. Within this perspective, I incorporated Knowles's core adult learning principles as guidelines in facilitating patients' learning. Knowles's conceptual framework, therefore, has been influential in adult learning activities (Finn, 2011).

Literature Review Saturation

To obtain articles pertinent to Knowles's adult learning principles, patient education, and morbidity rates, I entered different keywords including *postoperative complications, morbidity* and *mortality, quality improvement, patient teaching, cost effectiveness, self-directed learning, self-management, andragogy, nurse staffing, ER recidivism, information needs*, and *avoidable hospitalizations*. The Boolean operators (and, or, and not) added precision in searching relevant articles. To search for health sciences and nursing articles, I connected with Thoreau to quest for multiple databases. I also used cumulative index of nursing and allied health literature (CINAHL) for health and nursing databases. To ensure that I selected appropriate academic and scholarly journals, as well as peer-reviewed articles, I elected Ulrich's periodicals directory.

Using the Walden University Library website, I selected articles online under the CINAHL and medical literature analysis and retrieval system (MEDLINE). I also resorted to critiques on Malcolm Knowles's principles of adult learning.

There were more than 9,000 articles about adult learning, but restricted to 20 articles when I added the subject of Knowles. There were 300 articles about hospitals' quality management. There were more than 23,000 articles on patient education. All the articles collected were between 2008 and 2012. I have reviewed a combination of articles and textbooks about Knowles' conceptual framework, patient education, morbidity rates, and quality improvement measures.

Through this literature review, I learned that Knowles shared a number of important insights regarding the characteristics of adult learners including what and how

adults learn (Merriam et al., 2007). Knowles's set of learning assumptions is important in this project study because it provide a deeper understanding of the needs, styles, and interests of adult learners. This understanding will help health care providers and educators appreciate the adult learning practices (Knowles et al., 2011).

Implications

Implications from this project study provided the need for developing a comprehensive patient-centered education process in the ENT clinic. Applying Knowles's adult learning principles will be an added value in educating adult patients regarding perioperative expectations and teaching patients about avoidable postoperative complications. Recognizing the importance of teaching patients preoperatively at the CVAMC ENT clinic, a structured as well as comprehensive preoperative patient-education will help produce positive surgical outcomes.

Summary

In addition to using the theoretical framework of Knowles, the key points highlighted included the problem of postoperative complications. Hence, the increasing trend of postoperative complication rates generated a considerable interest to embark on a project study examining and exploring the patients' perceived information needs in ENT clinic prior to surgery.

The next section focuses on the research methodology of this project study. The participants answered an eight-item questionnaire using a 5-point Likert scale. These closed ended questions identified the patients' perceptions regarding the existing preoperative patient education information. I discuss the design and approach used in

this project study in the succeeding section. In the end, I discuss the proposed project and provide a reflection of the study.

Section 2: The Methodology

Introduction

The design and approach I chose for this project study was that of a descriptive study. This type of nonexperimental design helped me gain more information (Burns & Grove, 2011; Norwood, 2000) about patients' perceptions regarding the preoperative information provided in the ENT clinic. Conducting a descriptive study, I described patients' opinions, attitudes, and beliefs concerning the surgical information given to them prior to surgery. Using a preestablished survey developed by Henderson (2004), the participants answered eight questions in the survey using a Likert scale. The quantitative section of the survey was important because it examined the patients' perceptions of the preoperative patient education. The participants had the following choices in rating the information received prior to surgery: 1 = *strongly disagree*; 2 = *disagree*; 3 = *neither agree nor disagree*; 4 = *agree*; and 5 = *strongly agree*. The participants rated their level of agreement or disagreement with each of the following statements (Henderson, 2004):

- I received adequate information about the signs and signals indicating postoperative complications and when to seek medical help.
- I received adequate information explaining the possible complications of my surgical procedure.
- I received adequate information explaining how the surgery procedure will affect my lifestyle after discharge.
- I received adequate information explaining how the surgery/procedure will affect me in the first 24/48 hours.

- I received adequate information explaining why the doctor believes the surgery is necessary.
- I received adequate information about treatment alternatives including benefits and risks of each alternative.
- I received adequate information explaining how the doctor will perform the surgery.
- Prior to admission, I received adequate information about the type and personal details required by the hospital. (p. 964)

The qualitative section of the project study consisted of one open-ended question at the end of the questionnaire (Henderson & Chien, 2004): Why was the surgical preoperative information important to the patients? Reponses to this open-ended question provided information on how participants valued the patient education information provided to them prior to surgery.

Furthermore, as suggested by the VA R&DC, I added two supplementary questions in the survey. Due to the modifications in the preestablished survey, I also asked permission from Henderson and Chien (2004) to help gather more in-depth information from surgical patients (Henderson and Chien, personal communication, November 10, 2013). The questions added were as follows:

- What information do you feel should have been provided before your surgery that you did not receive regarding postoperative care?
- What other information do you think should have been addressed regarding your proposed surgery?

Particularly, the open-ended questions helped in elaborating and obtaining more data to follow-up on the quantitative section of the study (Mertens & Wilson, 2012). Indeed, the purpose of mixing qualitative and quantitative data in this single project study was to provide a better and more complete understanding of the problem.

For the data collection, the concurrent mixed method technique was selected. One unique feature of this strategy is its ability to integrate both quantitative and qualitative data in order to provide a comprehensive analysis of the problem (Creswell, 2008). Hence, I was able to gather two types of data during a single data collection phase. A characteristic of this mixed method technique was the time required in data collection.

The data analysis and summary of responses obtained from the survey questionnaires identified what information patients desire in order to achieve positive surgical outcomes. From this view, I offered recommendations that would guide and lead the future patient education program for ENT patients in our local facility. Overall, the findings from this study can be used to improve and/or change our practice in the ENT clinic.

As the intent of this quantitative and qualitative study were to determine the preoperative information needs of the patient population , this summative evaluation project provided insight on what areas of the preoperative patient education process works, what does not, and why patients find the information valuable. I used summative evaluation because summative data included scores from the Likert scale and participants' responses from the open-ended questions. Overall, the evaluation goal was

to obtain a better understanding of what information patients need to know before surgery to prevent avoidable complications and to achieve desirable outcomes after surgery.

Setting

The natural setting of this project study, also known as a field setting (Burns & Groves, 2011), was at the CVAMC ENT clinic. There was no manipulation or change in this natural setting. I conducted the project study in the clinic because patients returned for their postoperative appointments within 5–14 days after surgery. The patients completed the survey in a quiet clinic room, which was free of distractions.

Sampling Method

On average, there are four to nine patients scheduled every week for an ENT procedure in the operating room (OR). From these postoperative patients, I used convenience sampling method in selecting participants. For the same reason, Polit and Beck (2012) supported this nonprobability sampling technique because I can use the most conveniently available participants that meet the established eligibility criteria.

As such, I conducted the survey while patients were waiting for their postoperative appointments in the clinic's lobby. From this standpoint, there was no cost in mailing the surveys. There was no waiting period for the participants' response. Patients completed the surveys in clinic, which increased the chance of a high response rate.

Furthermore, there were no promotional advertisements in this project study. No form of reimbursements, compensations, tokens of appreciation, or incentives were provided for participation. Although unlikely, a patient may find filling out a

questionnaire about surgery a stressful event, especially if the surgical experience was not favorable from the patient's point of view. However, the benefits of improving the perioperative experience of patients outweighed the possible potential discomfort gained from completing the questionnaires.

After the patients completed the VA Research Consent Form 10-1086 and signed the Notice of Privacy Practice Act Form, the surveys were given in person at the time of their initial postoperative clinic appointment. First postoperative appointment is generally 5 to 10 days after surgery. This appointment was the optimal time to administer the questionnaire at the postoperative visit given that the patient is out of the acute care setting and will have had the experience of recovery during which time potential complications might have occurred. Hence, patients completed the questionnaire while waiting for their scheduled postoperative appointments in the ENT clinic.

The sample size depended on the number of patients showing up for their postoperative ENT appointments. Upon review of the clinic schedule between January 1, 2013 and March 30, 2013, two patients out of 25 missed their ENT postoperative appointments. Furthermore, in the following months between April 4, 2013 and June 30, 2013, there were 75 total postoperative appointments and three patients failed to come to their respective appointments. Considering the possibility of missed postoperative appointments and other situations that may pose difficulty for patients to participate in the study, the sample size for this descriptive study using convenience sampling strategy was 61 postoperative patients who underwent ENT surgery at the CVAMC.

The eligibility or sampling criteria for the study participants included the following:

- 18 years of age or older
- Patients who had ENT surgical procedure performed in the OR
- Ability to speak and read English
- Willingness to participate in research

These characteristics were fundamental for eligibility in the target population. I selected my sample from the accessible population that met these sampling criteria. Those excluded from the study were terminally ill, senile, or suffering from diminished decision-making capacity. Burns and Groves (2011) suggested excluding patients with cognitive impairment or mental illness because they are incapable of providing informed consent for the study.

The Concurrent Strategies

The participants answered a survey developed by Henderson (2004) known as the Patient's Need for Knowledge of Proposed Surgery (PNKPS). The PNKPS is divided in two sections: quantitative and qualitative.

Quantitative Sequence: Descriptions of Instrumentation or Data Collection

The first section of the PNKPS is the quantitative portion of the study. Participants answered eight closed-ended questions. This preestablished instrument measured the information that patients agreed should be presented before surgery.

Using descriptive statistics, I summarized the scores from the Likert scale. To find the mean, I added up the scores and divided it by the number of scores (Lodico et al., 2010). This measure of central tendency was necessary to determine the overall perceptions of participants on the information they received prior to surgery. Also, the frequency of each score was displayed by using frequency distribution. I calculated the standard deviation (*SD*). This measure of variability was important because *SD* represented the average deviation from the mean (Lodico et al., 2010). In essence, *SD* illustrated the degree to which scores were different from one another.

To conduct the descriptive statistics of the quantitative data, I used Statistical Package for the Social Sciences (SPSS) for Windows version 18.0 (Green & Salkind, 2011). I described the results by means of statistical indices. For instance, the mean and standard deviation of the eight items of the PNKPS were presented in tables.

In addition to calculating scores, I reviewed the reliability and validity of the PNKPS instrument. For this purpose, Henderson (2004) checked the reliability by using a pilot study. Checking for reliability is necessary in order to assess the degree of dependability and consistency of an instrument (Lodico et al., 2010). The type of reliability used for PNKPS was internal consistency. Henderson (2004) used Cronbach's alpha coefficient to examine the consistency of responses. The PNKPS had a Cronbach's

alpha coefficient of 0.88 (Henderson, 2004). Of note, 0.88 is a significant value because a value between .00 and +1.00 falls within the normal index of reliability (Nieswiadomy, 2008; Polit & Hungler, 1999). In general, the higher the coefficients, the higher the degree of internal consistency.

Equally important, Henderson (2004) assessed the validity of PNKPS instrument. Validity is crucial in evaluating a quantitative instrument because "it measures what it is supposed to be measuring" (Polit & Hungler, 1999, p. 418). The form of validity used for PNKPS instrument was content validity. A panel of experts, including registered nurses and surgical patients, examined PNKPS instrument using the content validity index (CVI). The experts evaluated the relevance of the underlying construct using a 4-point scale: 1 = *not relevant*, 2 = *somewhat relevant*, 3 = *relevant*, 4 = *very relevant*. The percentage of total items rated by the experts was 3 or 4, and the CVI score was 0.89 (Henderson, 2004). According to Polit and Hunger (1999), a score of .80 or better suggests having a good content validity; therefore, a CVI score of 0.89 is significant because the score indicated increased accuracy or acceptable level of validity.

The process needed to complete the questionnaire was simple. However, before participants could volunteer to participate, I discussed the purpose, benefits, risks, and possible precautions of the study. Then, participants read and signed the VA Research Consent Form 10-1086. Until I reached the desired sample size, I approached potential participants and distributed the questionnaires during the patients' postoperative visits in the ENT clinic. The survey took approximately 20 minutes to complete. Immediately

after completing the surveys, the patients met with the attending surgeon and/or ENT resident for a postoperative appointment.

All the raw data from my project study are available in the appendix section. Some examples of materials included in the appendix are research study approvals, the data collection instrument, the VA and UC research forms, the detailed scoring instructions, and the final form of the survey. The appendices contain relevant data, but the information was not incorporated into the study.

Explanation of the Data Used to Measure Variables

In this descriptive project study, there was no treatment or intervention. Therefore, there was no attempt to establish causality. Furthermore, this nonexperimental project study has no identifiable independent or dependent variables.

Qualitative Sequence

As indicated in the first section, the quantitative data contained the closed-ended questions. In the second section, by contrast, the qualitative data encompassed three open-ended questions. I analyzed and summarized the qualitative data from these open-ended questions using content analysis. According to Polit and Hungler (1999), *content analysis* involves "describing the characteristics of the content of the message" (p. 209). Polit and Beck (2012) and Vaismoradi, Turunen, and Bondas (2013) described content analysis as a traditional approach used in analyzing qualitative data by examining participants' responses. Nieswiadomy (2008) added that the responses are analyzed to identify key themes and patterns.

Similarly, Henderson and Chien (2004) and Loon, Vries, Weijden, Elwyn, and Widdershoven (2014) used the same content analysis method to identify the prominent themes and patterns that emerged from their study participants. In this project study, I performed a similar process, and then I translated verbal data into meaningful groupings or categories as displayed in Tables 2, 3, and 4 respectively.

This analytical step helped me make connections and provide explanations as to why preoperative surgical information is valuable to patients, what information patients feel they should have been provided before surgery regarding postoperative care, and what other information patients think should have been addressed regarding their proposed surgery.

Because I have been employed at the CVAMC ENT clinic, I had direct access to recruit potential participants. Nonetheless, prior to starting human research activities, the University of Cincinnati Institutional Review Board (UC IRB) and VAMC Research and Development Committee (R&DC) department reviewed and approved permission to conduct this study in the hospital (Tsan, Nguyen, & Brooks, 2013). I started my UC and VAMC R&DC application process in February 2013 and received approval of research protocol (Study ID #2013-2095) in July 2014. Additionally, the Office of Student Research Administration at Walden University approved both my doctoral study proposal and my application to the IRB (Approval # 01-22-14-0159287) in January 2014.

The procedure for gaining access to potential participants was straightforward. In many cases, I made preliminary contacts with the participants in the ENT clinic before surgery and during their postoperative clinic appointments. Due to the nature of the

preestablished survey I selected for this descriptive study, there was neither a number nor anticipated duration of interviews, observations, or focus group sessions. Instead, I asked the participants to answer only three open-ended questions at the end of the survey. In general, these open-ended questions offered participants the opportunity to answer each question in much more depth.

I had a close interaction/relationship with the participants. Due to this relationship, there was little issue of establishing trust with the participants and stakeholders including the nursing and surgery service. One important advantage I had as the key gatekeeper was my knowledge about the settings at work. To reinforce this idea, working within the CVAMC enabled me to collect meaningful data for evaluative purposes.

Using a triangulation, I compared and cross-checked data in validating responses of participants from the open-ended survey (Lodico et al., 2010). Triangulation, as Bekhet and Zauszniewski (2012) and Fotheringham (2010) emphasized, reduces researcher biases.

My professional position as the ENT nurse case manager was a significant advantage for the data collection process. As the scheduler of ENT cases in the OR, I had access to all the patients who had procedures completed. I also collaborated with the multidisciplinary team including speech pathologist, nutritionist, medical hematology and radiation oncologist, social worker, nurses, ENT residents, and chief of ENT surgery service. Moreover, I handled both inpatient and outpatient care issues.

Creswell (2008) and Polit and Hungler (1999) argued that there are several mixed methods data analysis approaches. However, I used the data transformation technique in this project study. This process involved counting the number of times the codes and themes occur in the open-ended section of the survey. Through this quantification of qualitative data, I was able to compare the results of the quantitative with the qualitative data. As I mentioned earlier, the strategy I chose for data collection is the concurrent mixed method approach. This design allowed collection of both forms of data at the same time. Following this approach, I was able to incorporate the quantitative and qualitative data to produce the most meaningful results.

Equally important in the data analysis was checking the validity as well as the trustworthiness of both the quantitative data and qualitative findings. Concerning the validity of data, Burns and Grove (2011) addressed important considerations when selecting a data-collection instrument. One essential component of research quality that Polit and Hungler (1999) asserted is using measuring instruments that are both valid and reliable. In one such case, Henderson chose internal consistency in checking for reliability of PKNPS, and the Cronbach's alpha coefficient was 0.88 for the total scale. Oroviogoicoechea, Watson, Beortegui, and Remirez (2009) and Rowell, Long, Chance, and Dolley (2012) emphasized that a high reliability coefficients indicated higher levels of reliability.

Polit and Beck (2012) asserted using experts in the field in appraising the relevance of the theoretical construct of interest. In such cases, Henderson (2004) selected staff nurses and surgical patients in the pilot test to establish the validity of

PKNPS. In fact, the selected panel of experts represented the sample that measured the construct of interest.

Burns and Grove (2011) highlighted if the chosen preestablished instrument measures the same or very similar construct. The idea or underlying theme that I desired to measure using survey questions was examining what are the perceived information needs in ENT clinic prior to surgery. After a careful analysis of Henderson's instrument, my project study measured constructs closely similar to Henderson's PNKPS.

The evidence of reliability and validity from an established instrument is a crucial component in conducting quality research (Creswell, 2008; Lodico et al., 2010; Polit & Hungler, 1999). In fact, Merriam (2009) asserted that reporting validity and reliability of measurements is used in research. Knowing that unreliable or invalid measures can adversely affect the results of a study (Creswell, 2009), I selected to use a preestablished instrument that had been tested for reliability and validity.

After data collection, I integrated both quantitative and qualitative data to best understand the project study problem. The integration of the findings provided an extensive discussion of the quantitative and qualitative analysis of data. The procedure for the integration of quantitative and qualitative data is using a concurrent mixed method. In an effort to recognize the patients' information needs, I examined their perceptions on the value of providing surgical information in the preoperative phase. Using a structured questionnaire, the PNKPS is the quantitative data that I used to assess what information patients agreed that should be provided prior to surgery. Furthermore,

the insights derived from the answers to the open-ended questions helped me understand why and what information is important to patients.

Data Analysis

In total, 81 patients underwent an ENT procedure in the OR between January 2014 and April 2014. The data collection started on January 27, 2014 and ended on April 28, 2014. Participants either had an outpatient surgery or required a relatively short hospitalization for observation such as quadscope with biopsy, microlaryngoscopy with biopsy, total or hemithyroidectomy, neck dissection, tonsillectomy, total laryngectomy, cochlear implant, septorhinoplasty, or septoplasty. From this population, I recruited 61 postoperative patients in the ENT clinic at the CVAMC using convenience sampling method. However, I excluded three participants from this project study because of missing signatures in their VA Research Consent Form 10-1086.

Out of the 58 participants, I recruited only one female patient. The age of the participants ranged from 30 to 84 years old. All the participants answered the quantitative portion of the survey by shading or marking an "X" on the response option of the Likert scale that best reflects their position or their perspectives regarding the preoperative patient education provided in ENT clinic. Subsequently, the participants also answered the three questions in the qualitative section of the survey. Of note, this concurrent mixed method approach illustrated the strategy I selected in presenting and analyzing the collected data. The system I used for keeping track of data was the master study log, which is the standard of practice in CRU at the CVAMC. In addition, I created

a log stored in a Word document for the quantitative and qualitative data. This logging process helped in understanding the emerging views of ENT patients.

Tables and Figures

The quantitative analysis indicated that a high number of participants perceived that they received adequate preoperative information. In contrast, only a limited number of the participants strongly disagreed. The distribution for each of the scores was small. The mean and SD of the eight items in PNKPS are displayed in Table 1. The highest score was a mean of 4.66 for item 5: "I received adequate information explaining why the doctor believes the surgery is necessary." On the other hand, the lowest score was a mean of 4.09 for item 6: "I received adequate information about treatment alternatives including benefits and risks of each alternative."

Similar to the findings of Henderson and Chien (2004), the mean value was 4 or above. Patients received adequate preoperative education prior to surgery. Based on these quantitative results, the providers in the ENT clinic may help lead or develop more formal, standardized operating practice teaching patients on what to expect before, during, and after surgery.

Further, the patients' opinions and thoughts gained from the three open-ended questions in the survey offered insight into the perioperative experiences of ENT patients undergoing surgery. Using a content analysis, I examined the responses obtained from 58 participants. Essentially, the analysis of 58 participants provided descriptive information on (a) why patients find the information important, (b) what information

patients feel should have been provided to them prior to surgery, and (c) what other notable preoperative information patients think should have been addressed.

I analyzed the participants' responses by manually categorizing the data into subject areas or themes. As supported by Polit and Hungler (1999), this technique is useful in understanding and interpreting the meaning from the content of the text data. Overall, the construction of themes captured the various perceptions of patients.

Predominantly in this study, the participants recounted the value of preoperative patient education in the ENT clinic to achieve successful surgical outcomes. As indicated in Table 2, the majority of surgical patients particularly expressed their desire for information in order to understand "what will happen" and "what to expect" before and after surgery. This finding correlated closely with the study of Noonan and Hegarty (2010) who agreed that unmet information causes significant psychological burdens and distress particularly among surgical patients. Therefore, provision of information to patients was an important factor.

Table 3 displays the support of participants for preoperative instruction as an intervention to achieve favorable effects on postoperative outcomes. The participants selected certain distinctive topics they feel providers should integrate into their preoperative instructions. Mainly, the participants suggested including the following crucial subject areas in educating patients:

- Management of postoperative pain
- Voice changes
- Anticipated wait time for biopsy results

- Approximate length of incision
- Tubes in my nose
- Wound care
- Nutrition and ability to eat
- Breathing and mouth care
- Heparin injections
- Calcium deficiency

Interestingly, some patients concurred that they received the information needed prior to surgery. In fact, participants noted that "All was covered," "Everything was explained," "I feel like I was prepared for postop care," and "I am very thankful to both the surgeons and the staff here." A patient even remarked, "Information was adequate probably more comprehensive than what is given at other medical facilities." Nonetheless, a few participants expressed concerns regarding issues such as discussion of alternative treatments, bringing personal effects in the hospital, whether or not they would be admitted postoperatively, and treatment/care at the CVAMC Emergency Room (ER) if needed for a complication.

Table 4 validated the information that patients perceived should have been addressed about their proposed surgery. A greater number of patients elected to discuss postoperative complications, risks or benefits, and side effects lacking/missing in patient education. Also, a margin of patients conveyed particular interest on important case management matters such as acceptable wait times on biopsy test results, pain medications, and postop disposition. Unexpectedly, some participants pointed out the

need to report the success rate of the proposed surgery. Nonetheless, a number of participants reported that the staff in ENT clinic provided "enough information."

Evidence of Quality

To assure the accuracy of the data, I used the triangulation strategy to confirm emerging findings in the study. Using multiple investigators fostered multiple perspectives and helped maximize validity of findings (Merriam, 2009). Triangulation is a method commonly used to avoid the possibility of biases; therefore, formulating credible findings (Holloway & Wheller, 2010; Polit & Beck, 2012; Polit & Hungler, 1999). With these concepts in mind, I chose the chief of ENT service and speech language pathologist at the CVAMC as the triangulating analysts to validate findings.

Outcomes

The findings from this mixed-method design generated a summary of the patients' perception of information needs before and after surgery. Results indicated that patients recognized a number of unmet information needs that, if filled, would help prepare them for surgery. As an outcome of this study, I will present an evaluation report to the following services: ENT, nursing, surgery, preadmission testing (PAT), nutrition, rehabilitation care line, postanesthesia care unit (PACU), and education. Also, I will present the findings to the Society of Otorhinolaryngology and Head-Neck (SOHN) association and to the Veterans Health Administration (VHA) Office of Nursing Services (ONS) Perioperative Field Advisory Committee (FAC). Both organizations support clinical nursing practice in identifying and recommending best practice guidelines to help improve patient care delivery.

Table 1

Item Mean and Standard Deviation of the PNKPS of Patients (n = 58)

Item	*M*	*SD*
I received adequate information about the signs and signals indicating postoperative complications.	4.40	.917
I received adequate information explaining the possible complications of my surgical procedure.	4.47	.903
I received adequate information explaining how the surgery/procedure will affect my lifestyle after discharge.	4.21	1.005
I received adequate information explaining how the surgery/procedure will affect me in the first 24/48 hours.	4.47	1.047
I received adequate information explaining why the doctor believes the surgery is necessary.	4.66	.739
I received adequate information about treatment alternatives including benefits and risks of each alternative.	4.09	1.189
I received adequate information explaining how the doctor will perform the surgery.	4.52	.800
Prior to admission, I received adequate information about the type of personal details required by the hospital	4.33	1.049

Note. Table adapted from Henderson, A. & Chien, W-T. (2004). Information needs of Hong Kong Chinese patients undergoing surgery. *Journal of Clinical Nursing, 13*(8), 960-966. Table adapted with permission.

Table 2

Why the Information Was Important to Participants?

Reason why information was important to them	Number of responses
The information helped me understand "what will happen" and " what to expect."	31
The information provided “peace of mind,” “comfort,” and “security.”	8
The information helped “plan and decide” and “made arrangements for recovery.”	2
The information helped me understand “how I feel about my body and health.”	6
The information was helpful because the doctors “make decisions based on data.”	1

Note. Table adapted from Henderson, A. & Chien, W-T. (2004). Information needs of Hong Kong Chinese patients undergoing surgery. *Journal of Clinical Nursing, 13*(8), 960-966. Table adapted with permission.

Table 3

What Information Do You Feel Should Have Been Provided Before Your Surgery That You Did not Receive Regarding Postoperative Care?

Missed information	Number of responses
1. Sequelae of treatment: "management of postoperative pain," "voice changes," "anticipated wait time for biopsy results," "approximate length of incision," "tubes in my nose," "wound care," "nutrition . . . not being able to eat," "breathing and mouth care," "heparin injections," and "calcium deficiency."	11
2. All information was adequate	11
3. Postoperative care at home	2
4. What is the success rate?	1
5. I don't know enough to ask any other questions	1
6. Discuss alternative treatments	1

Table 4

What other information do you think should have been addressed regarding your proposed surgery?

Other information needed	Number of responses
1. Postoperative complications, risks/benefits	9
2. No information needs	8
3. Case management concerns	5
4. What is the success rate?	5
5. I don't know enough to ask any other questions	2

Limitations

There were several noteworthy limitations of this study. As indicated, this project study was a descriptive study. I recognize that the method of data collection I chose using three open-ended questions might not provide a thorough and in-depth understanding of patients' perceptions. Thus, this limitation may offer a less detailed description of the patients' views regarding their information needs before surgery.I only collected a small sample of the ENT population using convenience sampling. Therefore, the risk for sampling bias was high (Polit & Beck, 2012) and limited the study's generalizability (Lodico et al., 2010).

Lastly, this project study is a summative report of the preoperative patient education in the ENT clinic. Lodico et al. (2010) favored the immediate benefit of using a formative approach in changing or improving practice.

Protection of Participants

The appropriate measures I acquired to protect the participants' rights included a careful review of my research plans with the IRB at Walden University and University of Cincinnati. Lodico et al. (2010) emphasized that the role of the IRB is to assess potential violation of human rights. For instance, the responses of the participants remain confidential; therefore, they cannot be shared with anyone.

Furthermore, the R&DC ensured that my study was in compliance with the VA research protocol. In addition to my abstract and project study proposal, I submitted several required forms including the following: VA research and development information system investigator data, VA research financial conflict of interest statement, VA informed consent (10-1086), Cooperative Technology Administration Agreement (CTAA), Laboratory Impact, Clinical Research Unit (CRU) needs assessment, Pharmacy impact, Chemical inventory, Subcommittee on Research Safety (SRS), Data Use and Security Plan, and Biological material survey attestation (C. James, personal communication, Feb 15, 2013) . Also, the R&DC application includes successful completion of the following online training courses in the VA Talent Management System (TMS): VA Privacy and Information Security Awareness and Rules of Behavior, Privacy and HIPAA Training, Organizational Ethics, and Collaborative Institutional Training Initiative (CITI) Program Training (n.d.).

I tracked the surveys returned on a daily basis by keeping a log in the M-drive of the hospitals' computer, which is a password-protected database. Each participant was de-identified. Then, I stored the returned surveys in a locked cabinet in the ENT clinic

(Room C-018) located in the basement of the hospital. This record keeping method was helpful in monitoring the response rate from the conveniently selected participants. After the study, all the records will be stored at a designated facility and will be disposed in accordance with the Department of Veterans Affairs' Records Control Schedule (RCS) 10-1 (U.S. Department of Veteran Affairs, 2011).

Every effort was made to maintain the confidentiality of patients' study records. Patients' identities remain confidential unless disclosure is required by law. The Department of Veterans Affairs and the University of Cincinnati will be allowed to inspect sections of patients' medical and research records related to this study. The data from the study may be published; however, patients will not be identified by name.

An additional means of protecting the rights of the participants is through informed consent (Lodico et al., 2010). Nieswiadomy (2008) asserted that informed consent is essential because it provides patients an explanation of the study including purpose of the study, selection of participants, potential risks and benefits, guarantee of anonymity, and right to participate or withdraw from study any time. All these elements of informed consent are crucial in guarding participants as well as addressing any ethical dilemmas that may arise.

Conclusion

This study's quantitative and qualitative data provided a summary of the patients' perspectives about their preoperative education needs in ENT clinic. The benefits of understanding the patients' opinions and thoughts may advance the ability to improve the perioperative experience for ENT patients in the future. With this in mind, the findings

may lead to the development of a more formal, standardized preoperative educational process. In the following section, I describe the white paper report.

Section 3: The Project

Introduction

In this project study, I highlighted the complexities of the participants' perceptions on their preoperative education needs. I analyzed both quantitative and qualitative data to strengthen the findings that resulted in the proposed project. The proposed project is the evaluation report, which in this case is the white paper (Appendix A).

Description of Proposed Project

White Paper Report

According to Purdue (2010), a white paper is an official government report used to recommend a solution to a problem. I selected the format of a white paper to present the identified problem. In addition to the problem that prompted this study, the other contents of this white paper include a review of literature addressing the problem, methodology and findings, recommendations, and references. Upon completion of the evaluation report, I will submit the white paper for review to the chief of general surgery service, chief of ENT service, a speech language pathologist, the OR nursing supervisor, and the chief of nursing service. I patterned this white paper after the guidelines established by the CDC in writing a final evaluation report. In addition, another reference I used was the Veterans Health Administration Fee Care Program – White Paper.

Project Genre

According to Walden University (2012), genre refers to the "structure or specific composition of the product that is being developed" (p. 19). From this description, the project was the evaluation report, and the product and genre was the white paper. Patterned from the workbook developed by the CDC (2011), this white paper offered a data review of a complex preoperative patient education process in the ENT clinic at CVAMC. Hence, this white paper report provided an assessment if the current preoperative practice of educating patients in the ENT clinic is meeting its objectives.

Goals of Proposed Project

Aligning with the problem of postoperative complications in the ENT service addressed in Section 1, the providers in the ENT clinic will use this white paper report to deliver the needed information to surgical candidates. In this sense, patients will learn what information they need to prepare for surgery; thus, patients will receive optimal treatments and will improve their surgical outcomes. Primarily, the goal of this project study was to examine the current preoperative educational process for surgical patients in the ENT clinic at CVAMC. Simply, the aforementioned description and goal support the purpose of a white paper in that it provided a means of offering a superior method to approach a specific problem (Purdue, 2010).

Rationale

I chose the white paper as the type of genre for this project because an evaluation report of the patients' perspectives and opinions might advance the ability to improve the perioperative experience for the ENT patients. Analysis of the data, as discussed in

Section 2, revealed that preoperative instruction as an intervention has positive effects on operative outcomes. Both quantitative and qualitative data uncovered considerable subject areas that patients find meaningful to learn. From this view, the white paper offered an explanation of how a structured educational program may address some of the unmet information needs of patients to prevent avoidable postoperative complications and to improve their surgical outcomes. I regarded this project as a potential solution to a problem I identified as a provider in the ENT clinic.

Review of Literature

Considered as a vital nursing action, Stavropoulou and Stroubouki (2014) postulated that an evaluation report helps with the decision-making process leading to improvement, development, and implementation of optimal programs. Additionally, Armstrong, Chemodurow, Christensen, and Johnson (2011) suggested that an evaluation of an education program resulted to patients' compliance to the recommendations and treatment regimens. Roca et al. (2012) assessed a patient education program, and results demonstrated that an evaluation of that program can be beneficial in determining patients' adherence to therapy.

Similarly, a white paper is relevant for the following reasons:

- The findings of the study will provide providers and management apparent strengths and potential limitations of the current preoperative patient education process.
- The analysis of the data will present providers and management areas in patient teaching that requires change or improvement.

- The results will add to the knowledge base for a patient education initiative.
- Finally, this summative evaluation report will offer recommendations for future planning and developing a structured patient education program in the ENT clinic.

In line with the content of this project, the problems will be addressed by identifying the challenges presented by the participants in this study. For example, several participants raised the question particularly related to management of avoidable postoperative complications. A number of participants articulated the need for the ENT surgeons to clearly discuss the risks, benefits, and alternative forms of treatment during the informed consent process. Such lack of information expressed by many participants may indicate a need for educational interventions to improve patient outcomes; thus, help reduce complication rates in the ENT service. This study involved 58 participants. Ortoleva (2010) stated that patient education plays a pivotal role in the postsurgical care outcomes and patient satisfaction.

CDC (2013) described a *final evaluation report* as a ”method of presenting the findings, conclusions, and recommendations from a particular evaluation, including recommendations for evaluation results can be used to guide program improvement and decision making” (p. 1). Grounded from this definition, this white paper report provides information as to whether the existing educational practice needs improvement, change, or modification. The summary of findings based from the participants’ perceptions of their surgical outcomes and experiences is significant in the decision making process. A

clear understanding of those findings, therefore, will enhance the providers' ability to translate the outcomes into practice.

As recommended by the CDC (2013) guidelines, an evaluation report should contain certain essential elements. These guidelines were established by CDC in 1999 and integrated the principles of the framework for program evaluation that still remain useful today in leading changes in public health programs (CDC, 1999/2013). In this final evaluation report, the contents include the following key elements:

- Executive summary: In this section, I provided a description of the patient education initiative in the ENT clinic, an explanation of the design and method used, and notable findings of the study.
- Intended use and users: In this section, I reviewed the intent of the patient-centered education process and who is likely the target patient population involved. Caffarella (2010) emphasized that identification of learners is the primary consideration indicated in the seven design steps when developing a program.
- Project study description: In this section, I presented the purpose and objectives of the patient education initiative. A clear narrative description helped understand why it was important to recognize the patients' preoperative needs in preventing avoidable postoperative complications; hence, improving patients' surgical outcomes.
- Data sources and methods: In this section, I described the data sources employed in the study, which were the patients' responses from the survey

questionnaires. Using a concurrent procedure method, I integrated both quantitative and qualitative data, hence, evaluating multiple viewpoints, perspectives, and standpoints of patients undergoing ENT surgical procedures. In addition, I also addressed in this section the statistical manipulations and the validity and credibility of data sources.

- Results, conclusions, and interpretations: In this section, I provided an opportunity to share the outcomes of the study. Basically, I displayed in this evaluation report how I measured the quantitative data from the participants' responses using the Likert scale. Additionally, I showed what information I elicited from participants regarding their perceived unmet preoperative information needs. In the end, I presented a table displaying a summary of the findings.
- Use, dissemination, and sharing plan: This section involved careful planning of reporting efforts. The recommendations focused on reviewing the current process and planning the future preoperative patient centered education program. However, CDC (2013) noted that this section is the most disregarded. Nonetheless, this content was useful because the findings were reported and channeled to the appropriate members and section chiefs in nursing and surgery services in our local facility.
- Tools for clarity: In this section, I included aids used in the study to help facilitate clarity including table of contents, tables, and references. At the end of the study, appendices will also be featured encompassing the survey

questions, data obtained from participants with de-identified information, approved VA Research Consent Form 10-1086, a copy of the letter of approval from the University of Cincinnati and VA R&DC, VA memorandum, and a number of VA forms required to initiate and to complete the study.

Overall, the evaluation report presented a clear description of (a) what the patient-centered education process entails, (b) how the process will be implemented, and (c) why the program matters in our patient population to prevent avoidable complications. To execute this evaluation report, I used the framework developed by CDC (2013) for program evaluation in public health (Figure 1). From this framework, there are the six key steps in developing and disseminating a final evaluation report. I integrated these steps in this evaluation report regarding the perspectives of patients on the preoperative patient education in the ENT clinic at the CVAMC.

Steps in Evaluation Report

Although I described the steps in a linear fashion, an overlap between steps may exist and it is common to revisit earlier steps. The first step in this evaluation report is "engaging the stakeholders" (CDC, 2013, p. 9). CDC (2013) asserted that identification of intended users with vested interest on the evaluation results is of paramount importance. Woodford and Preston (2011) explained that having full participation and cooperation of members, managers, or leaders in developing a new process may facilitate successful program implementation. Linnan et al. (2010) concurred that including stakeholders in the program improvement effort will generate positive results. Even

clinical nurses, Albanese et al. (2010) added, participating as stakeholders in quality improvement measures promote positive changes in clinical practice. Nonetheless, CDC stressed that the involvement of stakeholders starts from the beginning and continue until the reporting stage.

The second step is "describing the program" (CDC, 2013, p. 12). This next step involves stating the purpose and description of the patient education program initiative. I provided a clear statement of need and identified the problem as stated in Section 1, which is the high rate of postoperative complications in the ENT service in FY 2011. Also, the program description included goals, objectives, and criteria for success.

The third step is "focusing the evaluation design" (CDC, 2013, p. 17). Particularly in this step, I described the methods of sampling, data collection, data analysis, and interpretation of results. The concentration of this step addressed the issues of greatest concern to the stakeholders: Is the current process of educating our surgical patients effective in learning what to expect before and after surgery? Are the patients receiving adequate preoperative instructions to avoid postoperative complications? Is there a need to change our education practice in the ENT clinic?

The fourth step is "gathering credible evidence" (CDC, 2013, p. 19). According to CDC (2013), the stakeholders should regard the outcomes of the evaluation report credible for program improvement and decision making. Particularly in this step, I explained the purpose and rationale for using the triangulation method when integrating both quantitative and qualitative data. Accordingly, I used the triangulation technique to compare and contrast the ideas and interpretations of other researchers working closely

together in this project to achieve a better understanding of our preoperative patient education process.

The next step is "justifying conclusions" (CDC, 2013, p. 27). Considered important in this step are the analyses and interpretation of the data collected. The quantitative findings suggested that the majority of patients perceived a need for surgeons to address treatment alternatives including benefits and risks of alternatives. As a complementary follow-up from the quantitative data, I asked additional open-ended questions. The qualitative findings explored underlying themes associated with patients' desire for relevant topics prior to surgery including learning about postoperative complications. Collectively, interpretation of the results from the survey revealed that patients have various information needs that could be valuable in managing their care.

The overall findings are consistent with a review of the literature, which suggests that patients express satisfaction on patient education but recognize the need to improve preoperative information (Aziato & Adejumo, 2013; Harrison, Silverside, Oechslin, & Kovacs, 2011; Maruthapppu et al., 2010; Puro, Pakarinen, Korttila, & Tallgren, 2011).

The final step in this process of developing and disseminating a final evaluation report is "ensuring use and sharing lessons learned" (CDC, 2013, p. 30). According to CDC (2013), a well-written evaluation report could be a valuable instrument in reporting findings. A review by Treiber, Kipke, Satterlund, and Cassisy (2013) on local tobacco control projects revealed noncompliance with the standard reporting procedures. Realizing the value of a well-written evaluation report, Treiber et al. completed a study on the significance of report writing training and concluded that a training campaign may

show considerable improvements on the report quality. Agencies may make better use of their summary reports to highlight their aims/objectives, achievements, challenges and barriers, and recommendations by preparing a complete, high quality final evaluation report.

Another important consideration that should be included in the evaluation plan and report is sharing the lessons learned from the evaluation (CDC, 2013). Evidence from the literature indicates that communicating results is significant because it provides users and stakeholders' recommendations and strategies for enhancing programs (Deutschman, Ahrens, Cairns, Sessler, & Parsons, 2012; Jeskey, 2011; Schwarz, 2013; Steel & De Witte, 2011). CDC (2009) discussed several reasons to disseminate program information including promoting change in practices and addressing health issues. Taylor, Tooman, and Wells (2014) demonstrated a good example of how dissemination may restructure a specialty service program and captured the experiences of ENT patients in the first few years after diagnosis and treatment of cancer. As a result of their findings, they had an opportunity to recommend improvements on the treatments for head and neck cancer patients. This illustration supports the fundamental reason of sharing the outcomes of my study so the medical center leaders, nursing staff, and ENT providers can learn about the need to redesign the practice of educating the surgical patients.

As a final point, the CDC (2013) presented the evaluation standard attributes that will enhance the quality of program evaluation efforts. Adopted from the Joint Committee on Standards for Educational Evaluation and approved by American National Standards Institute (ANSI), these attributes have been endorsed by the American

Evaluation Association and 14 other professional organizations (Yarbrough, Shulha, Hopson, & Caruthers, 2011). These attributes are in the inner circle as depicted in Figure 1, namely the following:

- Utility standards – the evaluation should provide users and stakeholders with meaningful evaluation that would help meet, discover, and serve their needs. This standard will address: Who would benefit from the information and what information would they need?
- Feasibility standards – the evaluation should increase effectiveness and efficiency if executed in a realistic, practical, insightful, and cost-effective manner. This standard will address: How much money, time, and effort would we put into this?
- Propriety standards – the evaluation should be designed and conducted protecting the complex ethical and human rights of users and stakeholders. Also, evaluation should provide complete descriptions of findings, perceived conflicts of interests, and conclusions. This standard will address: What necessary measures would be considered for the evaluation to be ethical?
- Accuracy standards – the evaluation should yield reliable and adequate information. Furthermore, the evaluation should also include a clear documentation of design, data analyses, guard against biases, and interpretation of findings. This standard will address: What design would lead to accurate information?

Figure 1. CDC framework for program evaluation in public health. Adapted from Centers for Disease Control and Prevention. (2013). "Developing an effective evaluation report: Setting the course for effective program evaluation". Retrieved from http://www.cdc.gov/eval/materials/Developing-An-Effective-Evaluation-Report.

At its simplest, these standards facilitate evaluation activities that support a well-designed program evaluation effort. These standards are important because it answers the question "Will this evaluation be effective?" (CDC, n.d.). Concisely, the steps in evaluation together with the standards for effective evaluation will help guide the construction of an effective evaluation report of our patient education system in the ENT clinic at CVAMC.

With regard to adult learning, the results of the project study provided strong support for Knowles's assumptions of andragogy. In the light of the available evidence which suggests that Knowles's set of assumptions are valuable in adult learning situations (Arogundade, 2011; Chan, 2010; Knowles et al., 2011; Merriam et al., 2007), I recognized that his concepts can be used as a guideline in teaching adult patients. Based on the findings of this study, the submission of this white paper may be worthwhile to increase awareness of the different section chiefs, staffs, nurses, and supervisors regarding the need to enhance patient education in our patient population.

Consistent with the problem of postoperative complications at the CVAMC ENT service, Knowles's adult theory of learning is relevant in this project study. His framework helps in understanding the adults' learning style and practice (Knowles, 1984; Merriam et al. 2007; Merriam, 2009), which will be essential in the development of a standardized and structured patient education in ENT clinic. In essence, Knowles's theoretical framework will facilitate the learning of adult patients undergoing ENT surgical procedures.

Search Strategy - Saturation

I performed a systematic literature review of electronic databases using Thoreau, CINAHL, ProQuest, PubMed, Ovid, MEDLINE, and Nursing & Allied Health Source. Under the search options, the search mode I selected was Boolean/Phrase. Using a combination of words, I started operating a search on the subject of PE. The keywords used in the literature search were *adult learning, evaluation report, program implementation, patient-centered service, service redesign, patient experience, stakeholder participation, engagement, program development, performance measures, quality of care outcomes, health education, cancer prevention, and veterans*. Retrieved from google scholar, I located the framework of Centers for Disease Control and Prevention for program evaluation. Additionally, I found that numerous research articles that involved the keywords "genre evaluation report," were not labeled as such so I broadened the search to include program evaluation studies and white paper. The published dates were between January 2009 and August 2014, and I limited the search to articles in peer-reviewed journals where the primary language was English.

Implementation

Project Description

Implementation of my project study required completion of the white paper report. Upon approval of my doctoral study, the chief of ENT service and speech language pathology from the Rehab Care Line service reviewed my final evaluation report. Subsequently, I submitted the white paper to a panel (chief of Nursing, chief of

education, chief of ENT service, and chief of surgery services) to review my findings and recommendations.

Potential Resources and Existing Supports

The ENT service is one of the surgical specialties offered at the CVAMC, and it provides treatments in both the inpatient and outpatient settings (United States Department of Veteran Affairs [USDVA], n.d.). The chief of ENT service, Reena Dhanda-Patil, MD, MBA and Kathy Groves-Wright, SLP, Ph.D., support every educational intervention necessary to facilitate optimal outcomes of patients (R. Dhanda and K. Groves, personal communication, August 4, 2014). However, given the absence of a comprehensive and structured patient-centered preoperative method of teaching in the ENT clinic, I will seek other staff members for support.

Collaboration with other team members is essential in this evaluation report. Current literature shows important aspects of multidisciplinary team (MDT) efforts in planning and coordinating care of patients (Frank-Bader, Beltran, Dojlidko, 2011; Frieland et al., 2011; Lamb, et al., 2014). As experts, the multidisciplinary team members will provide their input answering the common or most frequently asked questions of patients pertaining to surgery.

In addition to the current patient education methods used in the ENT clinic including the iMEDConsent and the "Welcome to Surgical Service" handout (Appendix E), patients will also receive supplemental information that will focus on frequently asked questions prior to surgery. Of note, I obtained the supplemental information from the survey, which was identified by the participants in the study. This information will

help address patients' reservations regarding surgical complications and other perioperative issues.

For example, the head and neck registered dietitian will provide nutritional instructions. Previous studies explored by Van Stijn et al., (2013) and Evans, Martindale, Kiraly, and Jones (2014) demonstrated that poor nutrition status poses higher risk of mortality and morbidity of surgical patients. Additionally, Lambertz et al., (2010) emphasized the importance of addressing nutrition issues early in the course of treating head and neck cancer (H&NC) patients including monitoring laboratory values, calorie and protein intake, and weight. As mentioned in the study, "Not being able to eat and pain" and "What to do about food or lack of" are important pieces of information that participants' feel they should have been provided before surgery. From these views, proper nutrition before surgery plays a pivotal role in reducing occurrence of postoperative complications.

Attending surgeons collaborating with residents and other specialties including radiation oncology, medical oncology, medicine, psychiatry, pharmacy, dentistry, anesthesia, and social work services proved to be essential in managing treatment of patients (Bowen, 2014). Multidisciplinary team efforts show increased in survival rates (Friedland et al., 2011; Iwasa et al., 2013). In addition to collaboration, another important role of the surgeons addressed by Levinson, Hudak, and Tricco (2013) was a communicator of the complexities of the proposed invasive procedures, risks and benefits, and treatment choices. Effective communication covering the complications and benefits of the proposed surgical procedure helps patients make informed choices

(Kinnersley, 2013). Patients' concerns were transparent as mentioned in the open-ended section of the survey including the following:

- "I want to know as much as possible so I can understand what is happening with my sickness"
- "My parotid gland got infected about every other year and I want to know why"
- "How likely is it the surgery will work?"
- "Estimate rate of success of surgery"
- "After effects of surgery"
- "Chances of alterations of planned changes in procedure"
- "I understand funding is limited, but it would have been good to have alternatives. This is the only healthcare I have. I either do what the VA hospital says or I do without"
- "Risks involved when having a procedure"
- "Needed more information about what would happen when I got home"
- "Calcium deficiency after my damage to parathyroid and difficulty with abdomen from injections of Heparin"
- "How long till I can blow my nose again"
- "Benefits of removal"
- "Let me know what and why they're doing it"
- "What to expect postop for pain?"

- "What pain I would experience and what to do about it? How to make myself comfortable while resting?"
- "That a sore throat would be long and painful"
- "Possible encouragement that although painful, this surgery can very well change your life"
- "It was significant to have an understanding of the nature of the problems, especially consequences"
- "Just wondering if I should have tried a different treatment"
- 'How to deal with packing?" Those surgeries need an overnight stay to calm the patient, in my opinion"
- "They told me that I would have tubes in my nose, but I didn't so I was confused"
- "Medications when I went home"
- "Postoperative complications should be completely explained."

Another core member of the head and neck multidisciplinary team is the speech language pathologist (SLP). Their support ensures management of communication function and swallowing disorders of our H&NC patients (Yuen, Fallis, & Martin-Harris, 2010). One participant in the study uttered that he needed more information on "voice changes" after surgery. This example is important as indicated in the study of Freeman-Togher, Phipps, and Elkins (2011) that early assessment and intervention of SLP play a key role in restoring phonation in our tracheostomy patients.

Lastly, the participation of the ENT nurse case manager is imperative in the delivery of this evaluation report. This evaluation report will unveil topics and issues in the existing preoperative patient education process in the ENT clinic. Identification of the patients' perceptions is vital in understanding what information they need to know prior to surgery, why learning the information is important to them, and what questions and concerns they may have regarding postoperative care.

Potential Barriers

The ability to sustain observations of a decreasing number of adverse surgical events at the CVAMC ENT service as a result of our intervention may be problematic. One concern may be attributable to the fact that interventions rely on participation from a multidisciplinary team. Participation, based on our practice experience, may pose some challenges due to persistent staff shortages to meet the clinic and OR demands. Preparing staff for changes in the ENT patient education program will require active involvement from all concerned members. To end, engaging many key stakeholders to produce much-desired results can also be another challenge.

Similar to the limitations faced in executing the Veterans Health Administration (VHA) facility and quality safety report (United States Department of Veteran Affairs [USDVA], 2010), VHA's quality improvement in mental health (Watkins & Pincus, 2011), and the Veterans Health Administration Fee Care Program (Pane, Kizer, Shiplett, & Getter, 2011), these evaluation reports, however, were successfully implemented. As such, I also considered the potential barriers in this evaluation report. In any case, this evaluation report will be used for several reasons:

- Examine the impact of a structured and comprehensive educational activity in reducing postoperative complications
- Advance the understanding of how changing the educational process in a given clinical area may improve practice
- Evaluate performance of patient education initiative related to program outcomes
- Enhance patients' surgical outcomes
- Increase patients' satisfaction.

Proposal for Implementation and Timetable

The proposed structured and comprehensive patient-centered preoperative education will be implemented in FY 2015. I will share a preliminary report with the chief of ENT service and the speech language pathologist. In addition to the Walden University, I will also seek approval and acceptance of my doctoral study from VA R&DC. Then, I will deliver and discuss my final white paper to the chief of nursing, chief of education, and chief of surgery services. After a series of meetings with the multidisciplinary team and key stakeholders, I will also organize a PowerPoint presentation to present my findings and recommendations to a larger audience in our main auditorium at the CVAMC. Request for use of this setting will be submitted by the end of FY 2014.

Roles and Responsibilities of Student and Others Involved

The multidisciplinary team (MDT) shares information to produce collaborative care plans. Primarily, the team works together in providing optimal care to patients, and

there is growing evidence that a MDT can improve patient outcomes (Lamb et al., 2014; Levinson et al., 2013; McCahill et al., 2014). This section will briefly discuss the various roles and responsibilities of each team member:

- ENT surgeon and ENT residents – a specialist who practices all aspects of ENT medicine. They collaborate closely together with other different specialties including primary care providers, medicine/surgical team, psychiatry, oncology, audiology, and dental. The ENT specialists also create a comprehensive treatment plan before beginning treatment or surgical procedure. Prior to surgery, the ENT surgeons and/or residents educate patients regarding the proposed procedure using the iMEDConsent.
- Speech Language Pathologist – a specialist responsible for voice and speech therapy and treatment of swallowing disorders. This team particularly cares for patients who have undergone an ENT surgical procedure called laryngectomy, which is removal of the larynx (Ozturk & Mollaoglu, 2013). In addition, this experts provide speaking valves and augmentative communication devices as appropriate
- Registered Dietitian – a specialist working to improve the nutritional health of patients. The registered dietitian conducts a thorough nutrition assessment and monitors albumin levels prior to surgery. If needed, the dietitian works together with ENT surgeons/residents to provide nutrition by a nasogastric, percutaneous endoscopic gastrostomy (PEG), gastrostomy feeding tube or intravenous solution (Hejl & Furze, 2010).

- Social Worker – a specialist responsible for assessing the patients' living situations and support systems. They will work with ENT surgeons/residents for discharge planning back to home or to the community. This team will coordinate variety of services and programs available for veteran patients (United States Department of Veteran Affairs [USDVA], n.d.).
- Pre-Admission Testing (PAT) nurse – a specialist optimizing the patients' health status before surgery. The nurse informs the anesthesiologists any abnormal lab values or diagnostic testing particularly chest x-ray (CXR) and electrocardiogram (ECG). Included in the preoperative preparation, the PAT nurse evaluates, assesses, and educates patients ensuring safe surgical experience. Noted an important role of the PAT nurse, as emphasized by Reynolds (2011), is their contribution in decreasing surgical morbidities and reducing patients' anxiety through a preoperative education.
- Dentist – a specialist providing optimal oral health care of the head and neck cancer patients before and after their radiation and/or chemotherapy treatments (Rodes-Nesset & Laronde, 2014). Chang et al. (2013) argued that there is an association between poor oral hygiene and success in treating head and neck cancer. Therefore, their contributions in this evaluation report will be noteworthy.
- ENT nurse case manager – a nurse responsible for coordinating, planning, facilitating care of the ENT surgical patients. Referring to the case managers' role as crucial in the success of the multidisciplinary team by Brubakken,

Grant, Johnson, & Kollauf (2011), this nurse works closely with patients and families as well as community providers to ensure that surgeries proceed as scheduled. Preventing unnecessary cancellations and delays of surgeries, the case managers' role includes efficient OR utilization. Before surgery, the ENT case manager is responsible for distributing the "Welcome to Surgical Service" and the additional handouts about "Frequently Asked Questions." In addition, the ENT case manager ensures that patients completed the iMEDConsent, which is a process that includes the following (VA memorandum no. 11-43, 2013):

- Surgeon explained the proposed procedure, indications, likelihood of success, and described benefits, risks, and potential complications
- Surgeons discussed benefits of available alternatives including the option of no treatment
- Surgeons evaluated the patients' decision-making capacity
- Surgeons provided patient adequate time to understand the procedure and/or allowed time to discuss the plan with family or surrogate
- Patients agreed with the plan for diagnostic and therapeutic procedures.

All of the experts from MDT will focus on addressing the patients' identified unmet information needs collected from my study. Different services will provide their contributions on how to help improve the current preoperative patient education practice

in the ENT clinic. Taken all together, the central distinguishing feature of the MDT approach is providing answers to the frequently asked questions.

Project Evaluation

The type of evaluation conducted in this project study was summative evaluation. I assessed the ongoing preoperative patient education process in the ENT clinic using PNKPS survey. Through this survey, patients answered eight questions using a Likert scale. To solicit additional information regarding patients' views on preventing adverse events and improving their surgical outcomes, there were open-ended questions. I used the information from the summative assessments into the white paper to help decide whether the present patient education method should be adopted, continued, or modified for improvement.

Hence, the intent of the evaluation report is to improve practice (Lodico et al., 2010). Overall, the evaluation goal includes submitting and delivering my white paper to the key stakeholders for approval of the recommended modifications. Following the approval, the next step is to assess and evaluate effectiveness of the modified patient education method. In the future, collaboration with the section chief of ENT, the quality management nurse and the VASQIP nurse will be a valuable step to determine the sustainability of an improved O/E morbidity ratio in ENT service at the CVAMC.

In the next section, I will explore the impact of social change on improving the preoperative patient education. This section is important as it describes the implications of positive social change in our local facility and across all VA hospitals nationwide.

Implications Including Social Change

Local Community

From this project study, the implications for positive social change at our local facility will include increasing awareness on patients' perceptions concerning the preoperative information provided in the ENT clinic. Increasing awareness may change our educational practices in the ENT clinic; thus, improving the patients' surgical outcomes. Furthermore, coordinated efforts from MDT may lead to increased quality of patient care, optimal treatment, as well as increased in patient satisfaction (Lamb et al., 2014).

The findings from this project study are important because they may help the ENT service identify areas in teaching patients needing improvement, particularly preventing avoidable complications after surgery. Moreover, the social change may support the ENT service in developing a comprehensive patient-centered education process. Along the same line, providing the white paper report may also benefit other services in surgery including urology, orthopedics, neurosurgery, ophthalmology, obstetrics and gynecology, and general surgery at the CVAMC.

Far-Reaching

The impact on hospital cost due to adverse events is substantial. Fuller, McCullough, Bao, and Averill (2010) showed that postoperative complications resulted in an estimated 9.4% - 9.7% increase in inpatient hospital costs. Another study demonstrated that postoperative complications increased hospital cost 5 times

(Vonlanthen, 2011). It is for this reason that VASQIP, a nationwide VA quality database, monitors the postoperative complication rates in all VA hospitals (Mull, 2013).

With ever increasing medical costs, it is particularly important to find ways to prevent avoidable complications. From this view, there is growing evidence that a lack of patient education may lead to adverse surgical outcomes (Hari & Rosenzweig, 2012; Pool, Nadrian, & Pasha, 2012). Hence, an evaluation of the educational practices in ENT clinic was valuable.

Based on the outcomes of this project study, I will submit a white paper report that proposes a modification to our practice. Such change may enhance the future learning of the ENT surgical patients. The data further suggest that implementing a standardized preoperative patient education may help optimize their outcomes.

Conclusion

In the previous section, I described my proposed project. Also, I provided the goals, existing supports and potential barriers, a review of literature, discussion of findings, and social change implications. The highlight of Section 3 was an explanation why the project genre was chosen. Lastly, I also showed the format of the white paper report.

In the succeeding section, I concentrated on personal reflections about the proposed project. Further, I demonstrated the project's strengths and limitations in addressing the problem, recommendations, analysis, and directions of possible future research. To end, I summarized what was learned as well as overall relevance of the project study.

Section 4: Reflection and Conclusions

Introduction

This final section provides a summary of my project study. Overall, Section 4 focuses on my reflections that include the potentials and limitations of the project. I also review a number of recommendations for remediation of these limitations. Moreover, I reconsider how I can approach the problem differently including other probable alternatives to manage the problem of avoidable postoperative complications in the ENT surgery service.

By concluding with this section, I showcase an analysis of myself as a scholar, as a practitioner, and as a project developer. Also, I discuss the potential impact of social change both at the local and national levels. As a final point, I discuss a reflection on what I learned from this project study and its implications for future research.

Project Strengths

The greatest strength of my white paper report was enabling me to examine an identified critical problem in the ENT surgery service. The highlight of this project study concentrated on improving the patients' quality of surgical care and supporting its saving potentials from reducing the number of postoperative complications in the ENT service at CVAMC. Volanthen (2011) suggested that postoperative complications indicate poor surgical outcomes. Considering that the safety of the patients is our primary concern, I reviewed some possible ways to help sustain an O/E ratio of less than 1, which is an indicator that our patients had better postoperative results (Khuri et al., 2008). Within

this perspective, a decrease in the hospitals' adverse events reduces direct patient care costs, length of stay, and hospital readmissions (Maggard-Gibbons, 2014).

After exploring ways to sustain the number of postoperative complications, I decided to study the relevance of preoperative patient education in the ENT clinic. A concerted effort with my colleagues at our local facility including the VASQIP nurse, QI nurse, SLP, OR nursing supervisor, and chief of ENT service inspired me to complete a survey on our postoperative patients. The purpose of the survey was to evaluate if patients received adequate information to help them prepare for surgery, to reduce adverse events, and to improve their surgical outcomes.

Overall, the goal was to assess the patients' perceived information needs in the ENT clinic prior to surgery. Understanding the information needs of patient population regarding their perioperative care is essential. Based on the findings of my project study, a number of patients suggested a need for preoperative instructions to empower them with the skills and knowledge to actively participate in their own care.

Clearly, educational information can help patients become better informed about their perioperative care. Additional information brochures, which address the most commonly asked questions about surgery, may enhance patients' preparation for surgery. This collection of questions and concerns obtained from previous surgical patients may offer future surgical candidates a better understanding of their general perioperative experience.

In sum, the survey measured and studied the patient education process in the ENT clinic. As a result of this project study, I developed a white paper that featured an

evaluation report. Overall, this report defined the local problem that prompted this project study, analyzed the results and findings, and provided recommendations to change and to improve our practice.

Recommendations for Remediation of Limitations

There are limitations I identified on this project study. First, I restricted the amount of time in data collection. Hence, I only obtained 58 participants in the study. A small sample size may yield inaccurate results. Lodico et al. (2010) asserted and Nieswiadomy (2008) argued that a larger sample size is preferred because it represents and reflects the general population's traits. A recommendation for this remediation is simply to increase the sample size. A larger sample size is important, Burns and Grove (2011) explained, because it increases the chance of finding a significant difference between experimental groups.

Second, another limitation of the study may be related to my dual role as a principal investigator (PI) and the ENT case manager. Both roles may pose a possibility of bias, which can distort the findings and can threaten the study's validity and trustworthiness (Lodico et al., 2010). A strategy to address bias in this project study is to use the method of triangulation. Triangulation, Polit and Beck (2012) reasoned, validates the information collected and makes the study findings stronger.

Third, there were unforeseen setback and unexpected challenges in obtaining the Walden University IRB, UC IRB, and VA R&DC approval to conduct research. In fact, the whole process took 17 months before I received approval to conduct the study at my local facility. The delay also included a recommendation from VA R&DC to meet with

the Center for Clinical and Translational Science and Training (CCTST) staff. CCTST is a consulting agency that provides investigators assistance with research design and implementation (University of Cincinnati – Academic Health Center, n.d.). To remediate this limitation, an early exposure to the IRB application process may be valuable. Additionally, a strong nursing research mentor at my facility may alleviate some of the problems addressing VA research objectives and protocol; thus, avoiding further unnecessary delays.

Scholarship

Early in my doctoral course work, I was determined to embark on a project study at the CVAMC that would make a positive difference. There were numerous ideas that came to mind, but I was convinced to choose a journey that would improve the quality of patient care delivery in the ENT service. In my present position as the ENT nurse case manager, I sometimes hear what patients asked from their healthcare providers. Most commonly, my patients say "I wish I knew about this", "Nobody told me what to do", "When and why should I stop taking my medications?", "Why didn't they tell me that?", "What should I do in case?", or simply "Who should I call if?" After many years of nursing experience, it was evident that patients' information needs are not met considerably.

The doctorate of education at the Walden University has presented an opportunity to attain my passion in helping veteran patients achieve successful surgical outcomes. But, as a novice in the field of research, I confronted many challenges including developing a scholarly voice and refining my writing style. Undeniably, my

acquaintance with the writing center, the library, and the research center services at Walden University helped alleviate some of the fears, uncertainties, and reservations.

Nonetheless, a critical element in my scholarly quest remains unanswered: How can I better inform our surgical patients to prevent avoidable complications, to reduce recidivism, and to enhance patients' perioperative experience? Although research has shown that patient education is valuable in improving outcomes (Henselmans et al., 2011; Kruzik, 2009), little has been done, to the best of my knowledge, about developing and implementing preoperative education programs for the ENT surgical patients. So, it is my fervent hope that after 5 years on this scholarly mission, the efforts I presented in this white paper will be considered.

Project Development and Evaluation

The project development materialized because of the cooperation of some important colleagues in our local facility. Their involvement in the project study has made this white paper possible. Tracing back from the early beginnings of this project, it all started when the ENT service had a statistically O/E morbidity ratio in FY 2011 (VASQIP Nurse, personal communication, July 28, 2011). The high outlier status indicated a need for the facility to consider immediate quality improvement efforts.

Historically, the VHA implemented VASQIP to enhance surgical structures and to better manage surgical outcomes (Department of Veterans Affairs - National Surgery Office, 2013). Upon dissemination of the annual performance comparisons report, the VASQIP nurse meets and reports outliers with the hospital directors and chiefs of

different services. The VASQIP nurse and QI nurse immediately notify the involved section chief/s requiring immediate intervention.

After a series of meetings regarding viable options to facilitate a QI processes, I considered a project study researching on the patient education process in the ENT service through a survey. The objective is to determine if patients are receiving adequate patient education information to prevent avoidable adverse events. In addition, the study will improve practice and will increase patient safety. From these objectives, the chief of ENT service, VASQIP nurse, and QI nurse concurred to examine and to explore patient education. Lastly, I collaborated with the SLP from the Rehab Care Line to include her expertise with our head and neck cancer patients. With her knowledge in research, our work group coincided on a research question "What are the patients' perceived information needs in the ENT clinic prior to surgery?" Subsequently, our work group chose the project study title "Preoperative Education Needs in ENT Clinic: A Patient Perspective."

Following the project development, I evaluated the findings from the survey. Then, I presented the summary of findings in the white paper report, which addressed the issues surrounding adverse events and preoperative patient education in the ENT service. Of note, the white paper report was a joint effort with my colleagues at the CVAMC and with my project advisors at Walden University. In reality, their continuous feedback and support facilitated its completion.

Leadership and Change

Through this project study, I became acquainted with the role of a clinical nurse leader (CNL). Wesolowski, Casey, Berry, and Gannon (2014) demonstrated that a CNL in the perioperative setting at the USDVA can enhance surgical workflow by decreasing surgery cancellations and decreasing wait times or delay in treatment. In addition, the VHA supports the role of CNL in reducing length of patients' hospitalization, improving patient and staff satisfaction, and prevention of nosocomial infections (United States Department of Veteran Affairs [USDVA], n.d.). Further, Stavrianopoulos (2012) agreed that a CNL can improve the quality of patient care through effective team work.

The aforementioned studies are examples that leadership can advocate change. Such change may yield profound social consequences and may enhance nursing practice. Knowing what I learned from this project study about the relevance of educating our patient population before surgery, this white paper report will demonstrate to the key stakeholders the significance of the study. Furthermore, I added recommendations in the white paper report to illustrate that I closed a gap in practice, which may ameliorate patient outcomes.

Analysis of Self as Scholar

Before my doctoral journey in 2009, my knowledge was directly limited to nursing principles. I embraced some of the nursing theorists in my profession including Florence Nightingale, Dorothea Orem, Martha Rogers, and Betty Neuman. Each of their respective theories has its own conceptual framework and philosophical orientations, and they have helped me grow in my nursing career.

My perceptions as a scholar, however, have changed since I started at Walden University. The project study actually has expanded my knowledge of nursing by incorporating the adult learning principles of Knowles's (Knowles, 1975; Knowles, 1984). Indeed, I absorbed several critiques on Knowles's principles in this study; nonetheless, I still find his andragogical approach helpful when working with adult learners such as the veteran patients. Simply, an understanding of Knowles's principles is valuable because it may help maximize and encourage learning.

Analysis of Self as Practitioner

Before I started my doctor of education journey, I contemplated taking the doctor of nursing practice (DNP) degree. I chose the doctor of education program at Walden University because I was inspired by the social change mission. As a practitioner, I will have the advantage of using research to influence and to make a positive difference in my patients' lives by integrating nursing practice with education.

Though I had my share of challenges in obtaining approval to conduct research in our local facility, I find the entire experience rewarding. Also, my experiences with the IRB application process, both with University of Cincinnati and Walden University, were similarly difficult. Nevertheless, I painstakingly completed the survey, collected the data, and analyzed the findings. The project development, as a whole, has sharpened my skills in preparation for my future research endeavors.

Analysis of Self as Project Developer

In the past, I had some experience with minor project developments in our facility; however, I never had an opportunity to develop a white paper. Certainly, my

previous exposure with project development at the CVAMC was not as extensive as my doctoral project study. For this white paper report, I utilized all services available at Walden University to facilitate completion of my project study.

Of great importance, the Writing Center is one outstanding service that has helped me in the process. The Writing Center has exceptional trained instructors ensuring that my report follows the American Psychological Association (APA) form and style. I consistently submitted my papers for review, and the tutors provided tips and strategies in academic writing.

Another important service is the library. The library staff helped me in navigating databases and searching scholarly sources. Last, but not the least, is the research center. This particular service provided guidelines in IRB application and University Research Review (URR).

Overall, the project development was a complex and a demanding task. It required a great deal of planning and organizing. Without question, the project study has challenged me beyond my natural ability. My faculty advisors, however, helped me in refining the proposal, the methodology, and the final product of the project study.

The Project's Potential Impact on Social Change

Realizing the significance of providing patients with adequate information prior to surgery, I want to make a social change in the ENT service at the CVAMC. Walden University defined positive *social change* as "a deliberating process of creating and applying ideas, strategies, and actions to promote the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, and societies" (Walden

University, n.d., para. 4). From this definition, the social change of my project study is increasing awareness of the perceptions of patients regarding the information they received preoperatively. Raising awareness is important because of the following reasons:

- The health care providers in the ENT clinic and surgical candidates will be cognizant of the common questions and concerns of our patient population before surgery.
- The ENT surgeons will explain to patients the importance of preventing avoidable complications after surgery.
- The ENT surgeons will integrate the risks and benefits of surgery as well as review the alternative forms of treatment when discussing the surgical plans
- The comprehensive information provided to patients may increase their knowledge of improving patient outcomes, and
- Addressing the information needs of patients may lead to a development of a patient-centered education process.

The impact of raising awareness may change and improve patient education practice in our local facility. Research has shown that education has positive effects on patients' outcomes (Johnson et al., 2011; Kearney, Jennrich, Lyons, Robinson, & Berger, 2011). In fact, Ettema, Koeven, Peele, Kalkman, and Schuurmans (2014) and Harl and Rosenweig (2012) demonstrated that patients receiving educational intervention showed low incidence of readmissions related to postoperative complications; therefore, reducing the costs of care.

On a national level, the costs attributable to adverse events represent a large financial burden on hospitals (Fuller et al., 2009; Thompson & Magnuson). In most cases, Hauck, Zhao, and Jackson (2012) argued that poor surgical outcomes measure the hospitals' performance and reflect on the quality of patient care delivery and patient satisfaction as well. From this standpoint, lowering the occurrences of postoperative complication may result to high revenues in one hospital. Considering that the Veterans Health Administration is the largest health care system in the U.S. (United States Department of Veteran Affairs [USDVA], n.d.), the amount of savings will be substantial if avoidable surgical complications could be prevented in all one-hundred fifty medical centers.

Most importantly, a decrease in the adverse events increases patients' safety. Carey and Stefos (2011) discussed the association of high-cost of hospital services with adverse events. This study is important because it emphasized the significance of improving patient care while remaining focused on quality improvement measures, patient involvement, patient-centered approach, and staff awareness on patient safety initiatives. It is important to note that despite the concern of escalating hospital costs caused by a high incidence of preventable adverse events, the concentration of this project study is on the well-being of our patient population.

Implications, Applications, and Directions for Future Research

From this evaluation report and subsequent white paper, the implications of my study showed considerable information needs of our surgical patients. The quantitative and qualitative results of the survey unveiled the common and frequently asked

questions. Of significance in this project study, I learned that patients desire for more information before surgery. Some of the patients' concerns focus on postoperative care and complications. Predominantly, patients appeal for information about treatment alternatives including benefits and risks of each alternative. Contrary to my expectations of the survey results, many patients disclosed their unmet information needs. Some patients also suggested on improving our preoperative teaching method in the ENT clinic.

Although I have successfully navigated many of the issues related to postoperative complications, it is evident in our patient population that further research is warranted. Future research should be directed toward the level and appropriateness of education surrounding common surgeries scheduled in the ENT service. Such a research endeavor would attempt to tailor the education of patients specifically to the proposed surgery. Then, I will replicate the same study after a few months, but using a larger number of participants.

As a final point, I completed the data collection in this project study within a short duration. The data collected captured only a limited number of patients' perspectives. Considering that the quality improvement strategies should be continuous, it is imperative that healthcare providers assess and evaluate patient education interventions to optimize practice and patient outcomes.

The remaining section summarizes the project study report. This portion briefly describes the gap in practice, the effects of patient education, the impact of social change, the relevance of Malcolm Knowles's adult learning principles, and the significance of the white paper report.

Conclusion

In closing, I identified a problem in our local facility that prompted this study. Data from VASQIP showed that the ENT service at the CVAMC had a high outlier status in FY 2011. Although in FY 2012, the ENT service showed an improvement in the number of postoperative complications, the data further suggests a threat in sustainability.

There is growing evidence in research on the positive effects of patient education. But, in spite of our current efforts in educating our patients before surgery, avoidable postoperative complications remain evident. Hence, I noted a gap in practice.

To possibly close this gap in practice, I completed a survey that focused on examining and exploring the patients' perspectives regarding their preoperative education needs as well as experiences in the ENT clinic. Findings from the survey suggest that additional educational intervention such as recognizing the frequently asked questions may produce positive results on patients' surgical outcomes; therefore, reducing adverse events. Recent studies associated the decrease in serious adverse events at VA hospitals with proper communication, presence of teamwork, and standardization of clinical processes (Lee, Mills, Neily, & Hemphill, 2014; Mills, 2011).

In retrospect, a study evaluating the possible underlying reasons for the occurrences of the adverse events may yield improvement in patient care outcomes. The use of a white paper report may raise awareness of patients' concerning the preoperative information provided in the ENT clinic. Such awareness is the social change I am advocating in this project study. Although I recognized the challenges in sustaining a

high positive sustainability in the ENT service, the project study results suggest that patient education can change outcomes.

Lastly, I would like to give tribute to Malcolm Knowles's efforts in this project study. His learning principles have contributed to facilitating changes and improvements in our patient education process in the CVAMC ENT clinic. Knowles's principles of andragogy will be valuable in developing a patient-centered approach to teaching our patient population to work collaboratively with our team to improve their outcomes.

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Appendix A: The White Paper

Preoperative Education Needs in ENT Clinic: A Patient Perspective

Executive Summary

This white paper report provides a summative evaluation of the preoperative patient education in the ear, nose, and throat (ENT) service at the Cincinnati Veterans Administration Medical Center (CVAMC). Of note, this report captured only the overall findings from the beginning until the end of the survey, which covered only 3 months of data. For a better evaluation, a formative evaluation may be a more valuable approach in the future.

Overall, this report addressed the issues surrounding adverse events in our patient population. Also, I discussed the strengths and potential limitations of the current preoperative patient education process. Lastly, I identified a gap in practice. In the end, this report offers recommendations for future planning and developing a structured patient education program in the ENT clinic. Most importantly, I discussed the implications of a positive social change in our local facility

In retrospect, the Veterans Administration Surgical Quality Improvement Project (VASQIP) reported that the CVAMC ENT service presented an increase in observed versus expected (O/E) morbidity ratios in fiscal year (FY) 2011, indicating that the service has a statistically significant number of postoperative complications compared to the national average. These adverse events may result in life-threatening problems and increased costs for the hospital.

The purpose of this report is to examine ENT patients' perceived information needs regarding surgery and postoperative care. The research design is a descriptive

study using mixed methods. Through a nonprobability convenience sampling method, patients answered a survey. The survey has two parts. In the quantitative section, I identified the preoperative information needs of patients. Then, I explored the following questions in the qualitative section: (1) why the information is important to patients, (2) what information patients feel should have been provided before their surgery that they did not receive regarding postoperative care, and (3) what other information patients think should have been addressed regarding their proposed surgery. I analyzed the quantitative data using descriptive statistics, while using content analysis to summarize the qualitative data.

The results will be presented in a white paper report. Implications for positive social change at the CVAMC will include increasing awareness on patients' perceptions concerning the preoperative information provided in the ENT clinic. The impact of social change is helping the ENT service achieve sustainability on the levels of postoperative adverse events and enhancing patients' surgical outcomes.

This white paper report provides an assessment if the current preoperative practice of educating patients in the ENT clinic is meeting its objectives. Aligning with the problem of postoperative complications in the ENT service, the providers in the ENT clinic will use this white paper report to deliver the needed information to surgical candidates. In this sense, our patient population will learn what information they need to prepare for surgery; thus, patients will receive optimal treatments and will improve their surgical outcomes

Also, this white paper report discusses the implications for positive social change at the CVAMC, which includes increasing awareness on patients' perceptions concerning the preoperative information provided in the ENT clinic. In summary, the data analysis from this white paper report may potentially help the ENT service identify areas needing improvement in teaching patients. Most importantly, it may benefit the ENT service in developing a patient-centered education process focused on preventing avoidable complications after surgery.

The White Paper

I chose the white paper as the type of genre for this project because an evaluation report of the patients' perspectives and opinions will advance the ability to improve the perioperative experience for the ENT patients. Analysis of the data, as discussed in section 2, revealed that preoperative instruction as an intervention has positive effects on operative outcomes. Both quantitative and qualitative data uncovered considerable subject areas that patients find meaningful to learn. From this view, the white paper will offer an explanation of how a structured educational program may address some of the unmet information needs of patients to prevent avoidable postoperative complications and to improve their surgical outcomes. It is mainly for this reason that I regarded this project as a potential solution to a problem I identified as a provider in the ENT clinic.

In general, this white paper report is relevant for the following reasons:

- The findings of the study will provide providers and management apparent strengths and potential limitations of the current preoperative patient education process

- The analysis of the data will present providers and management areas in patient teaching that requires change or improvement.
- The results will add to the knowledge base for a patient education initiative
- Finally, this evaluation report will offer recommendations for future planning and developing a structured patient education program in the ENT clinic.

In the next section, I will discuss the importance of sharing the findings with the key stakeholders.

Intended Use and Users

An important consideration that should be included in the evaluation plan and report is sharing the lessons learned from the evaluation (CDC, 2013). Evidence from the literature indicates that communicating results is significant because it provides users and stakeholders' recommendations and strategies for enhancing programs (Deutschman, Ahrens, Cairns, Sessler, & Parsons, 2012; Jeskey, 2011; Schwarz, 2013; Steel & De Witte, 2011). CDC (2009) discussed several reasons to disseminate program information including promoting change in practices and addressing health issues. Taylor, Tooman, and Wells (2014) demonstrated a good example of how dissemination may restructure a specialty service program and captured the experiences of ENT patients in the first few years after diagnosis and treatment of cancer. As a result of reporting their findings, an opportunity presented on recommending improvements on the treatments for head and neck cancer patients. This illustration supports the fundamental reason of sharing the outcomes of my study so the medical center leaders, nursing staff, and ENT providers would learn the need to redesign our practice of educating our surgical patients.

From sharing the findings, I will further define the nature and scope of the project study problem and its impact in the next section. Also, I will explore the rationale for choosing the problem as well as the significance of the problem

Project Study Description

The Problem

Comparison of data from FY 2009 – FY 2011, the CVAMC ENT service showed a marked increase in the ratio of O/E adverse events. Although the ENT service revealed gradual progress on FY 2012 report, the data continued to evidence a substantial number of adverse events. Conversely, the FY 2013 report demonstrated improvement. Based on these inconsistencies, the data suggested a threat to sustainability on reducing postoperative adverse events. Evidence from data also supported the need to identify areas of substandard performance and potential causes of postoperative complications among our patient population. Hence, I reviewed on different possible factors affecting morbidity rates in the ENT service. Such efforts are essential to appreciate the maintenance of positive curves in overall health sustainability.

Relationship of the Problem at the CVAMC

One problem associated with postoperative complications is extending patients' length of stay in the hospital. Baehring and McCorkle (2012) showed that postoperative complications in head and neck surgery result in patients' delay in treatment, possible life-threatening problems, and an increase in medical costs. Simply put, Berenguer, Ochsner, Lord, and Senkowski (2010) concluded that adverse postoperative events complicate the quality of patient care and increase the costs of hospitalization.

Another problem emphasized by the chief of nursing service at CVAMC is the high level of nursing workload required for patients who have postoperative complications (B. Ackerson, personal communication, July 18, 2011). In fact, Hinno, Partanen, and Vehvilainen-Julkunen (2011) and Lin (2013) concluded in their study that high level of patient acuity may affect the quality of patient care. Bernard, Hunter, and Moore (2012) added that when patients display symptoms of complications, those symptoms warrant a higher demand of nursing care.

From the examples of increased days of hospitalization and high level of nursing workload, several studies suggested a direct link between postoperative complications and quality of patient care (Mark & Harless, 2009, Visser et al., 2012). Other studies also implied a direct relationship between postoperative complications and excess costs of hospitalization (Itani, 2009, McCullough, Weber, Leong, & Sharma, 2013; Rusu, Rusu, & Bulicrea, 2013; Zoucas & Lydrup, 2014). The problem of postoperative complications led Vaughan-Sarrain, et al. (2011) to complete a comprehensive analysis of costs in treating patients with complications and showed that patients with respiratory complications can cost one VA hospital up to $62,726. In addition, management of patients with other expensive treatments related to systemic sepsis and acute renal failure cost one veterans hospital more than $90,000.

In summary, Vaughan-Sarrain et al. (2011) concluded that decreasing incidence of morbidities will improve the quality of patient care. The decrease can also offer the hospital significant cost savings. Therefore, the implications of enhancing patient care and decreasing hospital costs will improve outcomes at the CVAMC.

Rationale for Choosing the Problem

Previous studies explored the concept that providing patients with adequate information regarding hospital admission processes, risks and benefits of surgery, and recovery time can improve patient outcomes (Foss, 2011; Hinami et al., 2014). Additionally, Aasa, Hovback, and Bertero (2012) and Foss (2011) examined the relevance of patient education, and their studies showed that providing patients with preoperative information is helpful. However, despite efforts of the ENT staff teaching surgical patients about perioperative expectations, the postoperative complications rate was relatively high in FY 2011. The adverse events suggested the need to study and to address this problem.

In addition, some of the staff members in surgery service also expressed their concerns regarding the problem of postoperative complications. For example, the quality management (QM) nurse conveyed the need to investigate on causative factors to improve surgical outcomes of patients (B. Dalton, personal communication, July 28, 2011). Moreover, the VASQIP nurse concurred with the need for quality improvement (QI) activities (J. Griffith, personal communication, July 28, 2011).

The section chief of ENT supported plans on making improvements in patient care and efforts in managing the hospitals' resources (R. Dhanda, personal communication, July 28, 2011). Furthermore, certain ENT patients including participants in the head and neck cancer support group voiced their opinions regarding the need for preoperative patient education on ways to prevent postoperative complications (K. Groves, personal communication, August 6, 2011).

In view of the relevance of teaching patients regarding perioperative expectations, the gap in practice related to the current patient education process in ENT clinic needs to be reviewed. The chief purpose of addressing the problem is to sustain as well as to decrease the number of postoperative adverse events in the ENT service.

Significance of the Problem

The VASQIP's rolling 12-month report displays the performance evaluation of each hospital (VA National Surgery Office Quarterly Report, 2012b). Romano et al. (2009) considered VASQIP a robust approach in surgical services because it led to marked improvements in surgical quality. For purposes of comparing the adverse outcomes with the national data average, the CVAMC was the high outlier in FY 2011 (VASQIP Nurse, personal communication, July 28, 2011). In fact, the CVAMC ENT service displayed an ascending trend of patients who had postoperative complications in FY 2011. This retrospective finding is the core of this project study.

To examine the different postoperative complications that may occur at CVAMC, I performed an in-depth chart review of ENT surgery cases between April 01, 2010 and March 31, 2011. For the purpose of this paper, *postoperative complication* is defined as "any unanticipated adverse event requiring intervention or prolonging length of stay" (Patel et al., 2009, p. 146). Unexpectedly, a complication of urinary tract infection (UTI) was the most common of the postoperative occurrences in ENT patients.

A UTI is a common healthcare-associated infection (Bernard et al., 2012; Dumont & Wakerman, 2010). The majority of the cases associated with UTI are due to use of an indwelling urinary catheter in hospitalized patients (Trautner, 2010). This

complication is also known as catheter-associated urinary tract infection (CAUTI) (Mara et al., 2009). Rothfield and Stickley (2010) found that CAUTI is a preventable surgical complication. Minimizing duration or limiting use of catheter only when indicated can prevent infectious complications and deaths (Bruminhent et al., 2010). According to Gould (2009), the Center for Disease Control (CDC) estimated 13,000 deaths annually attributed from CAUTI complication, and between $0.4 and $0.5 billion spent per year nationally to treat this complication. Given such data and figures, it is valuable for health care providers to teach patients ways to prevent complications postoperatively.

Additionally, complications affect total costs of hospitalization including increased length of stay in the hospital, nursing workload, supplemental expense on medications and treatments, and possible additional surgeries (Bosma, Veen, Jongh, & Roukema, 2011). From these points of view, studying the problem related to postoperative complications will be meaningful and useful for the ENT service at the CVAMC because it will help decrease the number of preventable adverse events. Subsequently, sustaining the O/E morbidity ratios will represent an optimal standard of surgical care. I discuss the design and approach used in this project study in the succeeding section. I review the recommendations that would guide and lead the future patient education program for ENT patients in our local facility.

Data Sources and Methods

The Methodology

The design and approach I chose for this project study was that of a descriptive study. This type of nonexperimental design helped me gain more information (Burns &

Grove, 2011; Norwood, 2000) about patients' perceptions regarding the preoperative information provided in the ENT clinic. Within this focus, this descriptive study described patients' opinions, attitudes, and beliefs concerning the surgical information given to them prior to surgery. Of note, this project study had no experimental elements including investigational drugs, therapeutic procedure, monitoring techniques, test procedures or medical devices.

Using a preestablished instrument developed by Henderson (2004), the participants answered eight questions in the survey using a Likert scale (Appendix B). The quantitative section of the survey is important because it examined the patients' perceptions of the preoperative patient education. The participants had the following choices in rating the information received prior to surgery: 1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly agree. Patients rated their level of agreement or disagreement with each of the following statements (Henderson, 2004):

- I received adequate information about the signs and signals indicating postoperative complications and when to seek medical help.
- I received adequate information explaining the possible complications of my surgical procedure.
- I received adequate information explaining how the surgery procedure will affect my lifestyle after discharge.
- I received adequate information explaining how the surgery/procedure will affect me in the first 24/48 hours.

- I received adequate information explaining why the doctor believes the surgery is necessary.
- I received adequate information about treatment alternatives including benefits and risks of each alternative.
- I received adequate information explaining how the doctor will perform the surgery.
- Prior to admission, I received adequate information about the type and personal details required by the hospital (p. 964)

The qualitative section of the project study consisted of one open ended question at the end of the questionnaire (Henderson, 2004): Why was the surgical preoperative information important to them. Reponses to this open ended question provided a complex picture of how participants valued the patient education information provided to them prior to surgery. Furthermore, I added supplementary questions in the survey:

- What information do you feel should have been provided before your surgery that you did not receive regarding postoperative care?
- What other information do you think should have been addressed regarding your proposed surgery?

Particularly, the open-ended questions helped in elaborating and obtaining more information to follow-up on the quantitative section of the study (Mertens & Wilson, 2012). Indeed, the purpose of mixing qualitative and quantitative data in this single project study was to provide a better and complete understanding of the problem.

The strategy for data collection is the concurrent mixed method technique. One unique feature of this strategy is its ability to integrate both quantitative and qualitative data in order to provide a comprehensive analysis of the problem (Creswell, 2008). I chose this strategy because it allowed collection of both quantitative and qualitative data simultaneously. Hence, I was able to gather two types of data during a single data collection phase. Therefore, an attractive characteristic of this method was the minimum amount of time required in data collection.

The data analysis and summary of responses obtained from the survey questionnaires identified what information patients desire in order to achieve positive surgical outcomes. From this view, I offered recommendations that would guide and lead the future patient education program for ENT patients in our local facility. Overall, the findings from this study can be used to improve and/or change our practice in the ENT clinic As the intent of this quantitative and qualitative study was to determine the preoperative information needs of our patient population, this summative evaluation project will provide an insight of what areas of the preoperative patient education process works, what does not, and why patients find the information valuable.

I used summative evaluation because I presented the findings at the end of the project study (Spaulding, 2008). The summative data included scores from the Likert scale and participants' responses from the open-ended questions. Overall, the evaluation goal is to obtain a better understanding of what information do patients need to know before surgery to prevent avoidable complications and to achieve desirable outcomes after surgery.

The next section is a discussion of the project study. A summary of results will be displayed in tables. This section also provides interpretations of findings.

The Project - Data Analysis

In total, 81 patients underwent an ENT procedure in the OR between January 27, 2014 and April 28, 2014. Participants either had an outpatient surgery or required a relatively short hospitalization for observation such as quadscope with biopsy, microlaryngoscopy with biopsy, total or hemithyroidectomy, neck dissection, tonsillectomy, total laryngectomy, cochlear implant, septorhinoplasty, or septoplasty. From this population, I recruited sixty-one postoperative patients in the ENT clinic at the CVAMC using convenience sampling method. However, I excluded three participants from this project study because of missing signatures in their VA Research Consent Form 10-1086.

Out of the 58 participants, I recruited only one female patient. The age of participants ranged from 30 to 84 years old. All the participants answered the quantitative portion of the survey by shading or marking an "X" on the response option of the Likert scale that best reflects their position or their perspectives regarding the preoperative patient education provided in ENT clinic. Subsequently, the participants also answered the three questions in the qualitative section of the survey. Of note, this concurrent mixed method approach illustrated the strategy I selected in presenting and analyzing the collected data. The system I used for keeping track of data is the master study log, which is the standard of practice in CRU at the CVAMC. In addition, I created

a log stored in a Word document for the quantitative and qualitative data. This logging process helped in understanding the emerging views of ENT patients.

Results, Conclusions, and Interpretations

The quantitative section of the project study indicated that a high number of participants perceived that they received adequate preoperative information. In contrast, only a limited number of the participants strongly disagreed. The distribution for each of the scores was small. Table 1 showed the mean and SD of the eight items in PNKPS. The highest score was a mean of 4.66 for item 5: "I received adequate information explaining why the doctor believes the surgery is necessary." On the other hand, the lowest score was a mean of 4.09 for item 6: "I received adequate information about treatment alternatives including benefits and risks of each alternative."

Similar to the findings of Henderson and Chien (2004), the mean value was 4 or above. This value is important because it indicates that patients received adequate preoperative education prior to surgery. Based on these quantitative results, the providers in the ENT clinic may help lead or develop more formal, standardized operating practice teaching patients on what to expect before, during, and after surgery.

Further, the patients' opinions and thoughts gained from the 3 open-ended questions in the survey offered insight into the perioperative experiences of ENT patients undergoing surgery. Using content analysis, I examined the responses obtained from fifty-eight participants. Essentially, the analysis of fifty-eight participants provided descriptive information on (a) why patients find the information important, (b) what

information patients feel should have been provided to them prior to surgery, and (c) what other notable preoperative information patients think should have been addressed.

I analyzed the participants' responses by manually categorizing the data into subject areas or themes. As supported by Polit and Hungler (1999), this technique is useful in understanding and interpreting the meaning from the content of the text data. Overall, the construction of themes captured the various perceptions of patients.

Predominantly in this study, the participants recounted the value of preoperative patient education in the ENT clinic to achieve successful surgical outcomes. As indicated in Table 2, the majority of surgical patients particularly expressed their desire for information in order to understand "what will happen" and "what to expect" before and after surgery. This finding correlated closely with the study of Noonan and Hegarty (2010) who agreed that unmet information causes significant psychological burdens and distress particularly among surgical patients. Therefore, provision of information to patients is an important factor, and it may improve surgical outcomes.

Table 3 displays the support of participants for preoperative instruction as an intervention to achieve favorable effects on postoperative outcomes. The participants selected certain distinctive topics they feel providers should integrate into their preoperative instructions. Mainly, the participants suggested including the following crucial subject areas in educating patients:

- Management of postoperative pain
- Voice changes
- Anticipated wait time for biopsy results

- Approximate length of incision
- Tubes in my nose
- Wound care
- Nutrition and ability to eat
- Breathing and mouth care
- Heparin injections
- Calcium deficiency

Interestingly, some patients concurred that they received the information needed prior to surgery. In fact, participants noted that "All was covered", "Everything was explained", "I feel like I was prepared for postop care", and "I am very thankful to both the surgeons and the staff here." More so, a patient even remarked that "Information was adequate probably more comprehensive than what is given at other medical facilities". Nonetheless, a few participants expressed concerns regarding issues such as discussion of alternative treatments, bringing personal effects in the hospital, whether or not they would be admitted postoperatively, and treatment/care at the CVAMC Emergency Room (ER) if needed for a complication.

Table 4 validated the information that patients perceived should have been addressed about their proposed surgery. A greater number of patients elected to discuss of postoperative complications, risks or benefits, and side effects lacking/missing in patient education. Also, a margin of patients conveyed particular interest on important case management matters such as acceptable wait times on biopsy test results, pain medications, and postop disposition. Unexpectedly, some participants pointed out the

need to report the success rate of the proposed surgery. Nonetheless, a number of participants reported that the staff in ENT clinic provided "enough information."

Evidence of quality

To assure the accuracy of the data, I used the triangulation strategy to confirm emerging findings in the study. Using multiple investigators fostered multiple perspectives and helped maximize validity of findings (Merriam, 2009). Triangulation is a method commonly used to avoid the possibility of biases; therefore, formulating credible findings (Polit & Beck, 2012, Polit & Hungler, 1999, Holloway & Wheller, 2010). With these concepts in mind, I chose the chief of ENT service and speech language pathologist at the CVAMC as the triangulating analysts to validate findings. They both independently analyzed and interpreted a set of data. Then, we compared our findings avoiding one-sided interpretations.

The findings from this mixed-method design generated a summary of the patients' perception of information needs before and after surgery. Results indicate that patients recognized a vast unmet information need that, if filled, would help prepare them for surgery. As an outcome of this study, I will present an evaluation report to the following services: ENT, nursing, surgery, preadmission testing (PAT), nutrition, rehab care line, post-anesthesia care unit (PACU), and education.

Recommendations

This white paper report offers a data review of a complex preoperative patient education process in the ENT clinic at CVAMC. The current patient education methods used in the ENT clinic includes using the iMEDConsent and the "Welcome to Surgical

Service" handout (Appendix E). In addition, the surgical candidates will also receive supplemental information that will focus on frequently asked questions prior to surgery. Of note, I obtained the supplemental information from the survey, which was identified by the participants in the study. This information will help address patients' reservations regarding surgical complications and other perioperative issues.

All of the experts from MDT will address the patients' identified unmet information needs collected from my study. Different services will provide their contributions on how to help improve the current preoperative patient education practice in the ENT clinic. Taken all together, the central distinguishing feature of the MDT approach is providing answers to the frequently asked questions.

The multidisciplinary team (MDT) shares information to produce collaborative care plans. Primarily, the team works together in providing optimal care to patients, and there is growing evidence that a MDT can improve patient outcomes (Lamb et al., 2014).

Table 1

Item Mean and Standard Deviation of the PNKPS of Patients (n = 58)

Item	Mean	SD
I received adequate information about the signs and signals indicating postoperative complications.	4.40	.917
I received adequate information explaining the possible complications of my surgical procedure.	4.47	.903
I received adequate information explaining how the surgery/procedure will affect my lifestyle after discharge.	4.21	1.005
I received adequate information explaining how the surgery/procedure will affect me in the first 24/48 hours.	4.47	1.047
I received adequate information explaining why the doctor believes the surgery is necessary.	4.66	.739
I received adequate information about treatment alternatives including benefits and risks of each alternative.	4.09	1.189
I received adequate information explaining how the doctor will perform the surgery.	4.52	.800
Prior to admission, I received adequate information about the type of personal details required by the hospital	4.33	1.049

Note. Permission granted from the authors to use the same table as presented in their paper. Adapted from Henderson, A. & Chien, W. T. (2004). Information needs of Hong Kong Chinese patients undergoing surgery. *Journal of Clinical Nursing, 13*(8), 960-966.

Table 2

Why the Information Was Important to Participants?

Reason for why information was important to them	Number of responses
The information helped me understand "what will happen" and " what to expect."	31
The information provided “peace of mind”, “comfort”, and “security.”	8
The information helped “plan and decide” and “made arrangements for recovery.”	2
The information helped me understand “how I feel about my body and health?”	6
The information was helpful because the doctors “make decisions based on data.”	1

Note. Permission granted from the authors to use the similar table as presented in their paper. Adapted from Henderson, A. & Chien, W-T. (2004). Information needs of Hong Kong Chinese patients undergoing surgery. *Journal of Clinical Nursing, 13*(8), 960-966.

Table 3

What Information Do You Feel Should Have Been Provided Before Your Surgery That You Did not Receive Regarding Postoperative Care?

Missed information	Number of responses
1. Sequela of treatment: "management of postoperative pain", "voice changes", "anticipated wait time for biopsy results", "approximate length of incision", "tubes in my nose", "wound care", "nutrition … not being able to eat", "breathing and mouth care", "heparin injections", and "calcium deficiency."	11
2. All information was adequate	11
3. Postoperative care at home	2
4. What is the success rate?	1
5. I don't know enough to ask any other questions	1
6. Discuss alternative treatments	1

Table 4

What other information do you think should have been addressed regarding your proposed surgery?

Other information needed	Number of responses
1. Postoperative complications, risks/benefits	9
2. No information needs	8
3. Case management concerns	5
4. What is the success rate?	5
5. I don't know enough to ask any other questions	2

Levinson et al., 2013; McCahill et al., 2014). This section will briefly discuss the various roles and responsibilities of each team member:

- ENT surgeon and ENT residents – a specialist who practices all aspects of ENT medicine. They collaborate closely together with other different specialties including primary care providers, medicine/surgical team, psychiatry, oncology, audiology, and dental. The ENT specialists also create a comprehensive treatment plan before beginning treatment or surgical procedure. Prior to surgery, the ENT surgeons and/or residents educate patients regarding the proposed procedure using the iMEDConsent.
- Speech Language Pathologist – a specialist responsible for voice and speech therapy and treatment of swallowing disorders. This team particularly cares

for patients who have undergone an ENT surgical procedure called laryngectomy, which is removal of the larynx (Ozturk & Mollaoglu, 2013). In addition, this experts provide speaking valves and augmentative communication devices as appropriate

- Registered Dietitian – a specialist working to improve the nutritional health of patients. The registered dietitian conducts a thorough nutrition assessment and monitors albumin levels prior to surgery. If needed, the dietitian works together with ENT surgeons/residents to provide nutrition by a nasogastric, percutaneous endoscopic gastrostomy (PEG), gastrostomy feeding tube or intravenous solution (Hejl & Furze, 2010).
- Social Worker – a specialist responsible for assessing the patients' living situations and support systems. They will work with ENT surgeons/residents for discharge planning back to home or to the community. This team will coordinate variety of services and programs available for veteran patients (United States Department of Veteran Affairs [USDVA], n.d.).
- Pre-Admission Testing (PAT) nurse – a specialist optimizing the patients' health status before surgery. The nurse informs the anesthesiologists any abnormal lab values or diagnostic testing particularly chest x-ray (CXR) and electrocardiogram (ECG). Included in the preoperative preparation, the PAT nurse evaluates, assesses, and educates patients ensuring safe surgical experience. Noted an important role of the PAT nurse, as emphasized by

Reynolds (2011), is their contribution in decreasing surgical morbidities and reducing patients' anxiety through a preoperative education.

- Dentist – a specialist providing optimal oral health care of the head and neck cancer patients before and after their radiation and/or chemotherapy treatments (Rhodes-Nesset & Laronde, 2014). Chang et al. (2013) argued that there is an association between poor oral hygiene and success in treating head and neck cancer. Therefore, their contributions in this evaluation report will be noteworthy.
- ENT nurse case manager – a nurse responsible for coordinating, planning, facilitating care of the ENT surgical patients. Referring to the case managers' role as crucial in the success of the multidisciplinary team by Brubakken, Grant, Johnson, & Kollauf (2011), this nurse works closely with patients and families as well as community providers to ensure that surgeries proceed as scheduled. Preventing unnecessary cancellations and delays of surgeries, the case managers' role includes efficient OR utilization. Before surgery, the ENT case manager is responsible for distributing the "Welcome to Surgical Service" and the additional handouts about "Frequently Asked Questions." In addition, the ENT case manager ensures that patients completed the iMEDConsent, which is a process that includes the following (VA memorandum no. 11-43, 2013):
    - Surgeon explained the proposed procedure, indications, likelihood of success, and described benefits, risks, and potential complications

- Surgeons discussed benefits of available alternatives including the option of no treatment
- Surgeons evaluated the patients' decision-making capacity
- Surgeons provided patient adequate time to understand the procedure and/or allowed time to discuss the plan with family or surrogate
- Patients agreed with the plan for diagnostic and therapeutic procedures.

All of the experts from MDT will focus on addressing the patients' identified unmet information needs collected from my study. Different services will provide their contributions on how to help improve the current preoperative patient education practice in the ENT clinic. Taken all together, the central distinguishing feature of the MDT approach is providing answers to the frequently asked questions.

In the succeeding section, I will explore the impact of social change on improving the preoperative patient education. This section is important as it describes the implications of positive social change in our local facility.

Implications Including Social Change

From this project study, the implications for positive social change at our local facility will include increasing awareness on patients' perceptions concerning the preoperative information provided in the ENT clinic. Increasing awareness may change our educational practices in the ENT clinic; thus, improving the patients' surgical outcomes. Furthermore, coordinated efforts from MDT may lead to increased quality of

patient care, optimal treatment, as well as increased in patient satisfaction (Lamb et al., 2014).

The findings from this project study are important because they may potentially help the ENT service identify areas in teaching patients needing improvement, particularly preventing avoidable complications after surgery. Moreover, the social change may support the ENT service in developing a comprehensive patient-centered education process. Along the same line, providing the white paper report may also benefit other services in surgery including urology, orthopedics, neurosurgery, ophthalmology, obstetrics and gynecology, and general surgery at the CVAMC.

Conclusion

In summary, I identified a problem in our local facility that prompted this study. Data from VASQIP showed that the ENT service at the CVAMC had a high outlier status in FY 2011. Although in FY 2012, the ENT service showed an improvement in the number of postoperative complications, the data further suggests a threat in sustainability.

There is growing evidence in research on the positive effects of patient education. But, in spite of our current efforts in educating our patients before surgery, avoidable postoperative complications remain evident. Hence, I noted a gap in practice.

To possibly close this gap in practice, I completed a survey that focused on examining and exploring the patients' perspectives regarding their preoperative education needs as well as experiences in the ENT clinic. Findings from the survey suggest that additional educational intervention such as recognizing the frequently asked questions may produce positive results on patients' surgical outcomes; therefore, reducing adverse events. Recent studies associated the decrease in serious adverse events at VA hospitals

with proper communication, presence of teamwork, and standardization of clinical processes (Lee, Mills, Neily, & Hemphill, 2014; Mills, 2012). In retrospect, a study evaluating the possible underlying reasons for the occurrences of the adverse events may yield improvement in patient care outcomes. The use of a white paper report may raise awareness of patients' concerning the preoperative information provided in the ENT clinic.

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Appendix B: The Survey

UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS

OUR COMMITMENT TO IMPROVE QUALITY OF PATIENT CARE
Veterans Administration Medical Center, Cincinnati, Ohio

Thank you for participating in this short survey to help us promote the importance of educating our patients in Ear, Nose, and Throat (ENT) clinic.

Your response will help us to identify areas in patient education needing improvement, particularly prevention of avoidable complications after surgery. Note that your answers will be strictly confidential.

Please rate your level of agreement or disagreement with each of the statements:

Do you believe that you need more information in the following areas prior to your surgery?	Strongly Disagree 1	2	Neutral 3	4	Strongly Agree 5
Information about the signs and signals indicating postoperative complications and when to seek medical help.	⬭	⬭	⬭	⬭	⬭
Information explaining the possible complications of my surgical procedure.	⬭	⬭	⬭	⬭	⬭
Information explaining how the surgery/procedure will affect my lifestyle after discharge.	⬭	⬭	⬭	⬭	⬭
Information explaining how the surgery/procedure will affect me in the first 24/48 hours.	⬭	⬭	⬭	⬭	⬭
Information explaining why the doctor believes the surgery is necessary.	⬭	⬭	⬭	⬭	⬭
Information about treatment alternatives including benefits and risks of each alternative.	⬭	⬭	⬭	⬭	⬭
Information explaining how the doctor will perform the surgery.	⬭	⬭	⬭	⬭	⬭
Prior to my admission information about the type of personal details required by the hospital.	⬭	⬭	⬭	⬭	⬭

Please explain why the information was important to you?

_____

_____

What is your understanding of the proposed surgery?

_____

_____

What further questions/concerns you have regarding your postoperative care?

_____

_____

Source: Henderson, A. & Chein, W-T. (2004). Information needs of Hong Kong Chinese patients undergoing surgery. *Journal of Clinical Nursing, 13*(8), 960-966.

Appendix C:

The Quantitative Results

QUANTITATIVE SURVEY RESULTS: 00001 - 00010

Please rate your level of agreement or disagreement with each of the statements:	Strongly Disagree 1	2	Neutral 3	4	Strongly Agree 5
1. I received adequate information about the signs and signals indicating postoperative complications and when to seek medical help?	0	0	1	3	6
2. I received adequate information explaining the possible complications of my surgical procedure?	0	1	0	2	7
3. I received adequate information explaining how the surgery/procedure will affect my lifestyle after discharge?	0	1	1	4	4
4. I received adequate information explaining how the surgery/procedure will affect me in the first 24/48 hours?	0	1	0	3	6
5. I received adequate information explaining why the doctor believes the surgery is necessary?	0	0	1	1	8
6. I received adequate information about treatment alternatives including benefits and risks of each alternative?	0	0	4	2	4
7. I received adequate information explaining how the doctor will perform the surgery?	0	0	1	2	7
8. Prior to admission, I received adequate information about the type of personal details required by the hospital?	0	0	2	1	7

QUANTITATIVE SURVEY RESULTS: 00011 - 00020

Please rate your level of agreement or disagreement with each of the statements:	Strongly Disagree 1	2	Neutral 3	4	Strongly Agree 5
1. I received adequate information about the signs and signals indicating postoperative complications and when to seek medical help?	0	2	1	3	4
2. I received adequate information explaining the possible complications of my surgical procedure?	0	1	1	3	5
3. I received adequate information explaining how the surgery/procedure will affect my lifestyle after discharge?	0	2	0	3	5
4. I received adequate information explaining how the surgery/procedure will affect me in the first 24/48 hours?	0	3	0	3	4
5. I received adequate information explaining why the doctor believes the surgery is necessary?	0	1	2	1	6
6. I received adequate information about treatment alternatives including benefits and risks of each alternative?	0	4	3	0	3
7. I received adequate information explaining how the doctor will perform the surgery?	0	1	4	1	4
8. Prior to admission, I received adequate information about the type of personal details required by the hospital?	0	2	1	3	4

QUANTITATIVE SURVEY RESULTS: 00021 - 00030

Please rate your level of agreement or disagreement with each of the statements:	Strongly Disagree 1	2	Neutral 3	4	Strongly Agree 5
1. I received adequate information about the signs and signals indicating postoperative complications and when to seek medical help?	0	0	0	2	8
2. I received adequate information explaining the possible complications of my surgical procedure?	0	0	0	1	9
3. I received adequate information explaining how the surgery/procedure will affect my lifestyle after discharge?	0	0	0	2	8
4. I received adequate information explaining how the surgery/procedure will affect me in the first 24/48 hours?	0	0	0	0	10
5. I received adequate information explaining why the doctor believes the surgery is necessary?	0	0	0	1	9
6. I received adequate information about treatment alternatives including benefits and risks of each alternative?	0	0	1	1	8
7. I received adequate information explaining how the doctor will perform the surgery?	0	0	0	3	7
8. Prior to admission, I received adequate information about the type of personal details required by the hospital?	0	0	0	3	7

QUANTITATIVE SURVEY RESULTS: 00031 - 00040

Please rate your level of agreement or disagreement with each of the statements:	Strongly Disagree 1	2	Neutral 3	4	Strongly Agree 5
1. I received adequate information about the signs and signals indicating postoperative complications and when to seek medical help?	0	0	1	3	5
2. I received adequate information explaining the possible complications of my surgical procedure?	1	0	0	3	5
3. I received adequate information explaining how the surgery/procedure will affect my lifestyle after discharge?	1	0	2	2	4
4. I received adequate information explaining how the surgery/procedure will affect me in the first 24/48 hours?	1	0	0	1	7
5. I received adequate information explaining why the doctor believes the surgery is necessary?	0	0	0	2	7
6. I received adequate information about treatment alternatives including benefits and risks of each alternative?	0	0	1	2	6
7. I received adequate information explaining how the doctor will perform the surgery?	0	0	0	2	7
8. Prior to admission, I received adequate information about the type of personal details required by the hospital?	1	0	1	1	6

QUANTITATIVE SURVEY RESULTS: 00041 - 00050

Please rate your level of agreement or disagreement with each of the statements:	Strongly Disagree 1	2	Neutral 3	4	Strongly Agree 5
1. I received adequate information about the signs and signals indicating postoperative complications and when to seek medical help?	0	0	2	0	8
2. I received adequate information explaining the possible complications of my surgical procedure?	0	0	0	3	7
3. I received adequate information explaining how the surgery/procedure will affect my lifestyle after discharge?	0	0	2	3	5
4. I received adequate information explaining how the surgery/procedure will affect me in the first 24/48 hours?	0	0	0	1	9
5. I received adequate information explaining why the doctor believes the surgery is necessary?	0	0	0	1	9
6. I received adequate information about treatment alternatives including benefits and risks of each alternative?	0	1	1	1	7
7. I received adequate information explaining how the doctor will perform the surgery?	0	0	0	3	7
8. Prior to admission, I received adequate information about the type of personal details required by the hospital?	0	0	3	0	7

QUANTITATIVE SURVEY RESULTS: 00051 - 00059

Please rate your level of agreement or disagreement with each of the statements:	Strongly Disagree 1	2	Neutral 3	4	Strongly Agree 5
1. I received adequate information about the signs and signals indicating postoperative complications and when to seek medical help?	0	1	0	1	5
2. I received adequate information explaining the possible complications of my surgical procedure?	0	1	0	2	4
3. I received adequate information explaining how the surgery/procedure will affect my lifestyle after discharge?	0	1	0	3	3
4. I received adequate information explaining how the surgery/procedure will affect me in the first 24/48 hours?	0	1	0	1	5
5. I received adequate information explaining why the doctor believes the surgery is necessary?	0	1	0	1	5
6. I received adequate information about treatment alternatives including benefits and risks of each alternative?	0	1	0	3	3
7. I received adequate information explaining how the doctor will perform the surgery?	0	1	0	0	6
8. Prior to admission, I received adequate information about the type of personal details required by the hospital?	0	1	0	2	4

QUANTITATIVE SURVEY RESULTS: 00060 - 00061

Please rate your level of agreement or disagreement with each of the statements:	Strongly Disagree 1	2	Neutral 3	4	Strongly Agree 5
1. I received adequate information about the signs and signals indicating postoperative complications and when to seek medical help?	0	1	0	1	0
2. I received adequate information explaining the possible complications of my surgical procedure?	0	0	0	2	0
3. I received adequate information explaining how the surgery/procedure will affect my lifestyle after discharge?	0	0	0	2	0
4. I received adequate information explaining how the surgery/procedure will affect me in the first 24/48 hours?	0	1	0	0	1
5. I received adequate information explaining why the doctor believes the surgery is necessary?	0	0	0	1	1
6. I received adequate information about treatment alternatives including benefits and risks of each alternative?	0	0	1	1	0
7. I received adequate information explaining how the doctor will perform the surgery?	0	0	0	1	1
8. Prior to admission, I received adequate information about the type of personal details required by the hospital?	0	0	0	1	1

QUANTITATIVE SURVEY RESULTS TOTAL: 00001 - 00061

Please rate your level of agreement or disagreement with each of the statements:	Strongly Disagree 1	2	Neutral 3	4	Strongly Agree 5
1. I received adequate information about the signs and signals indicating postoperative complications and when to seek medical help?	0	4	5	13	36
2. I received adequate information explaining the possible complications of my surgical procedure?	1	3	1	16	37
3. I received adequate information explaining how the surgery/procedure will affect my lifestyle after discharge?	1	4	5	19	29
4. I received adequate information explaining how the surgery/procedure will affect me in the first 24/48 hours?	1	6	0	9	42
5. I received adequate information explaining why the doctor believes the surgery is necessary?	0	2	3	8	45
6. I received adequate information about treatment alternatives including benefits and risks of each alternative?	0	6	11	10	31
7. I received adequate information explaining how the doctor will perform the surgery?	0	2	5	12	39
8. Prior to admission, I received adequate information about the type of personal details required by the hospital?	1	3	7	11	36

Appendix D: The Qualitative Results

QUALITATIVE SURVEY RESULTS: 00001 - 00010

Please explain why the information was important to you?
a. None - 3
b. I needed info and guidance
c. I had surgery on my ear and it was good to know what will and had happen.
d. Made me feel secure and comfortable
e. I want to be healthy for the rest of my life.
f. Decisions are made based on data.
g. To know what is ahead for me.
h. Put my mind on ease having this surgery.

What information do you feel should have been provided before your surgery that you did not receive regarding postoperative care?
a. None – 7
b. Cannot think of anything to add.
c. Voice changes, results of biopsy, waiting so long are uncomfortable.
d. All was covered.

What other information do you think should have been addressed regarding your proposed surgery?
a. None – 6
b. How likely it is the surgery will work.
c. Maybe estimate of success rate.
d. That I would have results ASAP. I was told that biopsy results will be in 48 hours. I waited 8 days.
e. Blood clumps and how to remove them and how long after surgery I could start removing them.

QUALITATIVE SURVEY RESULTS: 00011 – 00020

Please explain why the information was important to you?
a. None – 3
b. Needed to know what is going on.
c. I want to know as much as possible so I can understand what is happening with my sickness.
d. My parotid gland got infected about every other year and I want to know why.
e. I worked in health care for many years and I think all patients deserve information about procedures and risks.
f. It’s not
g. It lets me make better decisions about events in my life and better planning for those events.
h. I believe that everybody wants to know what is going to happen to them.

What information do you feel should have been provided before your surgery that you did not receive regarding postoperative care?
a. None – 5
b. That a sore throat would be long and painful.
c. Alternatives.
d. I was told my incision would only be 1 cm instead it was 1 in – and not minor at all.
e. Bring any change of clothing or personal products.
f. I understand funding is limited, but it would have been good to get outside alternatives, possibilities. This is the only health care I have. I either do what the VA hospital says or I do without.

What other information do you think should have been addressed regarding your proposed surgery?
a. None – 4
b. After effects of surgery.
c. I don't know enough to ask any other questions.
d. Chances of alterations of planned changes in procedure.
e. Give a sample of medicine or antibiotic to take with you.
f. I understand the question, but I am not sure of a good answer.
g. They gave me enough info.

QUALITATIVE SURVEY RESULTS: 00021 – 00030

Please explain why the information was important to you?
a. Gives me a sense of ease about the procedure
b. It will let me know what was being done
c. Anytime there is surgery done, things can happen. They can be fatal. So, always risk involved when having a procedure
d. So I know what was wrong
e. Foresight what is expected
f. Let me know what's going to happen, why it is happening, what is to expect
g. I needed to know
h. Peace of mind
i. Made me more at ease
j. Knowing what to expect

What information do you feel should have been provided before your surgery that you did not receive regarding postoperative care?
a. None – 6
b. I think they explained things very well
c. They told me that I would have tubes in my nose but I didn't so I was confused.
d. Care and dressing issue after surgery
e. Pain. What to do about food or lack of.

What other information do you think should have been addressed regarding your proposed surgery?
a. b. None – 5
b. Maybe if there would be after effects regarding my vision
c. How long till I can blow my nose again
d. It was covered well prior to surgery
e. Good job
f. Everything was pretty much explained

QUALITATIVE SURVEY RESULTS: 00031 – 00040

Please explain why the information was important to you?
a. None – 2
b. Information prevents future problems
c. I only had one eye and I wanted to make sure that it was not injured.
d. To give me a good idea what was happening.
e. This was a life altering and a forever changes. It affected all aspects of my health and well-being for the benefit hopefully of a better outcome which already is felt.
f. Everything was explained well.
g. I believe that the staff did an excellent job informing me about the operation and what to expect. It put my mind at ease.
h. Because it involves my future lifestyle.

What information do you feel should have been provided before your surgery that you did not receive regarding postoperative care?
a. None – 3
b. How surgery affects breathing and dry mouth care.
c. Just a 1 inch incision ends up on old thyroid scare.
d. Needed more information about what would happen when I got home.
e. Calcium deficiency difficulty after my damage to parathyroid and difficulty with abdomen from injections of Heparin – never given or explained.
f. Everything was explained.
g. I believe that they believe that there was such low chances of complications that after the follow-up call the next day no call again and it took ill the day after. I went to the ER and waited 6 hours before anyone could see me. If I had known that it is going to take that long, I would have gone to an outside urgent care facility. Other than that, I think I received excellent pre and postoperative information and care.
h. I'm good.

What other information do you think should have been addressed regarding your proposed surgery?
a. None – 4
b. How to care for dry mouth or prevention of dry mouth
c. The benefits of removal on other conditions

d. Medications when I went home.
e. Be prepared to stay better than prepared to leave.
f. Everything was explained.
g. I'm good.
QUALITATIVE SURVEY RESULTS: 00041 – 00050

Please explain why the information was important to you?
a. No comment
b. To fully understand the total experience
c. I got a lot of previous information on the pre and post procedures
d. To be prepared for what is going to be done to me.
e. Personal
f. Satisfied my mind
g. To let me know what and why they're doing it.
h. So, I would know
i. Ease my mind
j. My body and my life

What information do you feel should have been provided before your surgery that you did not receive regarding postoperative care?
a. No comment - 5
b. The information was strongly agreed
c. The information I received was adequate
d. I received all I needed
e. I knew everything
f. Just wondering if I should have tried a different treatment. But the doctor did explain why surgery was needed.

What other information do you think should have been addressed regarding your proposed surgery?
a. No comment - 5
b. Side effects, if any.
c. I was well informed
d. Why wait so long for biopsy results
e. How to deal with the "packing". Those surgeries need an overnight stay to calm the patient, in my opinion.

QUALITATIVE SURVEY RESULTS: 00051 – 00059

Please explain why the information was important to you?
a. No comment -
b. Help me understand what and why.
c. It allowed me to make proper arrangements at work to be off and what to expect postop for pain and recovery.

d. To understand what was going to happen and why.
e. So that I know
f. The information was very informative and told me what to expect after surgery.
g. Because I was very reserved on having the surgery – Great job. I feel better!
h. Need to know what I am going through.
i. Being informed was excellent
j. It was significant to have an understanding of the nature of the problems, especially consequences.

What information do you feel should have been provided before your surgery that you did not receive regarding postoperative care?
a. No comment – 3
b. Not being able to eat and pain.
c. I feel like I was prepared for postop care and I am very thankful to both the surgeons and the staff here.
d. None that I am aware.
e. Anything and everything had no idea what pain I would experience and what to do about it. Was surgery a success? How to make myself comfortable while resting.
f. Information was adequate probably more comprehensive than what is given at other medical facilities.

What other information do you think should have been addressed regarding your proposed surgery?
a. No comment – 4
b. The pain afterwards and how to deal with it.
c. Possible encouragement that although painful, this surgery can very well change your life. Just being able to breath is so wonderful.
d. How long pain would be and what kind of pain?
e. I feel everything was addressed.
f. Postoperative complications should be completely explained.

Survey Question #1: Please explain why the information was important to you?	Evaluator #1	Evaluator #2	Evaluator #3	Final Analysis
Theme 1: The information helpedme understand "what will happen" and "what to expect." = **31**	1. I needed info and guidance. 2. I had surgery on my ear and it was good to know what will and had happen. 3. To know what is ahead of me. 4. Needed to know what is going on. 5. I want to know as much as possible so I can understand what is happening with my sickness. 6. My parotid gland to infected about every other year and I want to know why. 7. I worked in health care for many years and I think all patients deserve information about procedures and risks.	1. I needed info and guidance. 2. I had surgery on my ear and it was good to know what will and had happen. 3. To know what is ahead of me. 4. Needed to know what is going on. 5. I want to know as much as possible so I can understand what is happening with my sickness. 6. My parotid gland to infected about every other year and I want to know why. 7. I worked in health care for many years and I think all patients deserve information about procedures and risks.	1. I needed info and guidance. 2. I had surgery on my ear and it was good to know what will and had happen. 3. To know what is ahead of me. 4. Needed to know what is going on. 5. I want to know as much as possible so I can understand what is happening with my sickness. 6. My parotid gland to infected about every other year and I want to know why. 7. I worked in health care for many years and I think all patients deserve information about procedures and risks.	1. I needed info and guidance. 2. I had surgery on my ear and it was good to know what will and had happen. 3. To know what is ahead of me. 4. Needed to know what is going on. 5. I want to know as much as possible so I can understand what is happening with my sickness. 6. My parotid gland to infected about every other year and I want to know why. 7. I worked in health care for many years and I think all patients deserve information about procedures and risks. 8. I believe that everybody wants to know what is going to happen to them. 9. It will let me know what was being done 10. Anytime there is surgery done, things can happen. They can be fatal. So, always risk involved when having a procedure 11. So I know what was wrong 12. Foresight what is expected 13. Let me know what’s

	8. I believe that everybody wants to know what is going to happen to them. 9. Gives me a sense of ease about the procedure 10. It will let me know what was being done 11. Anytime there is surgery done, things can happen. They can be fatal. So, always risk involved when having a procedure 12. So I know what was wrong 13. Foresight what is expected 14. Let me know what's going to happen, why it is happening, what is to expect 15. I needed to know 16. Knowing what to expect 17. Information prevents future problems 18. I only had one eye and I	8. I believe that everybody wants to know what is going to happen to them. 9. It will let me know what was being done 10. Anytime there is surgery done, things can happen. They can be fatal. So, always risk involved when having a procedure 11. So I know what was wrong 12. Foresight what is expected 13. Let me know what's going to happen, why it is happening, what is to expect 14. I needed to know 15. Knowing what to expect 16. Information prevents future problems 17. I only had one eye and I wanted to make sure that it was not injured.	8. I believe that everybody wants to know what is going to happen to them. 9. It will let me know what was being done 10. Anytime there is surgery done, things can happen. They can be fatal. So, always risk involved when having a procedure 11. So I know what was wrong 12. Foresight what is expected 13. Let me know what's going to happen, why it is happening, what is to expect 14. I needed to know 15. Knowing what to expect 16. Information prevents future problems 17. To give me a good idea what was happening. 18. I believe that the staff	going to happen, why it is happening, what is to expect 14. I needed to know 15. Knowing what to expect 16. Information prevents future problems 17. I only had one eye and I wanted to make sure that it was not injured. 18. To give me a good idea what was happening. 19. To fully understand the total experience 20. I got a lot of previous information on the pre and post procedures 21. To be prepared for what is going to be done to me 22. To let me know what and why they're doing it. 23. Help me understand what and why. 24. So, I would know 25. So that I know 26. To understand what was going to happen and why 27. The information was very informative and told me what to expect after surgery 28. Need to know what I am going through. 29. Being informed was excellent. 30. It was significant to have an understanding of the nature of the problems, especially consequences 31. Everything was explained well.

	wanted to make sure that it was not injured 19. To give me a good idea what was happening 20. To fully understand the total experience 21. I got a lot of previous information on the pre and post procedures 22. To be prepared for what is going to be done to me. 23. To let me know what and why they're doing it 24. So, I would know 25. Help me understand what and why 26. To understand what was going to happen and why. 27. So that I know 28. The information was very informative and told me what to expect after surgery	18. To give me a good idea what was happening. 19. Everything was explained well 20. To fully understand the total experience 21. I got a lot of previous information on the pre and post procedures 22. To be prepared for what is going to be done to me 23. To let me know what and why they're doing it. 24. So, I would know 25. Help me understand what and why. 26. To understand what was going to happen and why. 27. So that I know 28. The information was very informative and told me what to expect after surgery 29. Because I	did an excellent job informing me about the operation and what to expect. It put my mind at ease 19. To be prepared for what is going to be done to me. 20. To let me know what and why they're doing it. 21. So, I would know 22. Help me understand what and why. 23. It at work to be off and what to expect postop for pain and allowed me to make proper arrangements recovery. 24. To understand what was going to happen and why 25. So that I know 26. The information was very informative and told me what to expect after surgery.	

	29. Need to know what I am going through 30. Being informed was excellent 31. It was significant to have an understanding of the nature of the problems, especially consequences	was very reserved on having the surgery – Great job. I feel better! 30. Need to know what I am going through. 31. Being informed was excellent 32. It was significant to have an understanding of the nature of the problems, especially consequences	27. Need to know what I am going through. 28. Need to know what I am going through. 29. Being informed was excellent. 30. It was significant to have an understanding of the nature of the problems, especially consequences	
Theme 2: The information provided "peace of mind", "comfort", and "security." **= 8**	1. Made me feel secure and comfortable 2. Put my mind on ease having this surgery 3. Peace of mind 4. Made me more at ease 5. I believe that the staff did an excellent job informing me about the operation and what to expect. It put my mind at ease. 6. Satisfied my mind 7. Ease my	1. Made me feel secure and comfortable. 2. Put my mind on ease having this surgery. 3. Gives me a sense of ease about the procedure. 4. Peace of mind. 5. Made me more at ease. 6. I believe that the staff did an excellent job informing me about the operation and what to expect. It put my mind at	1. Made me feel secure and comfortable. 2. Put my mind on ease having this surgery. 3. Gives me a sense of ease about the procedure. 4. Made me more at ease 5. Satisfied my mind 6. Ease my mind 7.	1. Made me feel secure and comfortable. 2. Put my mind on ease having this surgery. 3. Gives me a sense of ease about the procedure. 4. Peace of mind. 5. Made me more at ease 6. I believe that the staff did an excellent job informing me about the operation and what to expect. It put my mind at ease 7. Satisfied my mind 8. Ease my mind.

	mind	ease 7. Satisfied my mind. 8. Ease my mind		
Theme 3: The information helped "plan and decide" and "made arrangements for recovery." **= 2**	1. It lets me make better decisions about events in my life and better planning for those events 2. Because it involves my future lifestyle. 3. It at work to be off and what to expect postop for pain and allowed me to make proper arrangements recovery	1. It lets me make better decisions about events in my life and better planning for those events 2. It at work to be off and what to expect postop for pain and allowed me to make proper arrangements recovery.	1. It lets me make better decisions about events in my life and better planning for those events	1. It lets me make better decisions about events in my life and better planning for those events 2. It at work to be off and what to expect postop for pain and allowed me to make proper arrangements recovery
Theme 4: How I feel about my body and health? **= 6**	1. I want to be healthy for the rest of my life 2. This was a life altering and a forever changes. It affected all aspects of my health and well-being for the benefit hopefully of a better outcome which already is felt. 3. Personal 4. My body and my life. 5. Because I	1. I want to be healthy for the rest of my life 2. This was a life altering and a forever changes. It affected all aspects of my health and well-being for the benefit hopefully of a better outcome which already is felt. 3. Because it involves my future lifestyle.	1. I want to be healthy for the rest of my life 2. This was a life altering and a forever changes. It affected all aspects of my health and well-being for the benefit hopefully of a better outcome which already is felt. 3. Because it involves my future lifestyle.	1. I want to be healthy for the rest of my life 2. This was a life altering and a forever changes. It affected all aspects of my health and well-being for the benefit hopefully of a better outcome which already is felt. 3. Because it involves my future lifestyle. 4. Personal 5. My body and my life. 6. Because I was very reserved on having the surgery – Great job. I feel better!

	was very reserved on having the surgery – Great job. I feel better!	4. Because it involves my future lifestyle 5. Personal 6. My body and my life.	4. Personal 5. My body and my life. 6. Because I was very reserved on having the surgery – Great job. I feel better!	
Theme 5: The information is helpful because the doctors "make decisions based on data = **1**	1. Decisions are made based on data	1. Decisions are made based on data	1. Decisions are made based on data	1. Decisions are made based on data
Survey Question #2: What information do you feel should have been provided before your surgery that you did not receive regarding postoperative care?	Evaluator #1	Evaluator #2	Evaluator #3	Final Analysis
Theme 1: Sequela of Treatment = **11**	1. Voice changes, results of biopsy, waiting so long are uncomfortable 2. That a sore throat would be long and painful. 3. I was told my incision would only be 1 cm instead it was 1 in – and not minor at	1. Voice changes, results of biopsy, waiting so long are uncomfortable 2. All was covered. 3. That a sore throat would be long and painful 4. I was told my incision would only be 1 cm instead it	1. Voice changes, results of biopsy, waiting so long are uncomfortable 2. That a sore throat would be long and painful 3. I was told my incision would only be 1 cm instead it was 1 in – and not minor at	1. Voice changes, results of biopsy, waiting so long are uncomfortable 2. That a sore throat would be long and painful 3. I was told my incision would only be 1 cm instead it was 1 in – and not minor at all. 4. They told me that I would have tubes in my nose but I didn't so I was confused 5. Care and dressing issue after surgery. 6. Pain. What to do about

	all. 4. They told me that I would have tubes in my nose but I didn't so I was confused 5. Care and dressing issue after surgery. 6. Pain. What to do about food or lack of. 7. How surgery affects breathing and dry mouth care. 8. Just 1 inch incision ends up on old thyroid scare. 9. Calcium deficiency difficulty after my damage to parathyroid and difficulty with abdomen from injections of Heparin – never given or explained 10. Not being able to eat and pain. 11. Anything and everything had no idea what pain I would experience and what to do about it. Was surgery a	was 1 in – and not minor at all. 5. They told me that I would have tubes in my nose but I didn't so I was confused. 6. Care and dressing issue after surgery 7. Pain. What to do about food or lack of 8. How surgery affects breathing and dry mouth care 9. Just a 1 inch incision ends up on old thyroid scare. 10. Calcium deficiency difficulty after my damage to parathyroid and difficulty with abdomen from injections of Heparin – never given or explained 11. Everything was explained. 12. Everything was explained. g. I believe that they believe that there was such low chances of complications	all. 4. They told me that I would have tubes in my nose but I didn't so I was confused 5. Care and dressing issue after surgery. 6. Pain. What to do about food or lack of. 7. How surgery affects breathing and dry mouth care 8. Just a 1 inch incision ends up on old thyroid scare 9. Calcium deficiency difficulty after my damage to parathyroid and difficulty with abdomen from injections of Heparin – never given or explained. 10. Not being able to eat and pain.	food or lack of. 7. How surgery affects breathing and dry mouth care 8. Just a 1 inch incision ends up on old thyroid scare 9. Calcium deficiency difficulty after my damage to parathyroid and difficulty with abdomen from injections of Heparin – never given or explained. 10. Not being able to eat and pain. 11. Anything and everything had no idea what pain I would experience and what to do about it. Was surgery a success? How to make myself comfortable while resting.

	success? How to make myself comfortable while resting.	that after the follow-up call the next day no call again and it took ill the day after. I went to the ER and waited 6 hours before anyone could see me. If I had known that it is going to take that long, I would have gone to an outside urgent care facility. Other than that, I think I received excellent pre and postoperative information and care		
		13. The information was strongly agreed		
		14. The information I received was adequate		
		15. I received all I needed.		
		16. I knew everything		
		17. Just wondering if I should have tried a different treatment. But the doctor did explain why surgery was		

		needed		
		18. Not being able to eat and pain.		
		19. I feel like I was prepared for postop care and I am very thankful to both the surgeons and the staff here.		
		20. None that I am aware.		
		21. Anything and everything had no idea what pain I would experience and what to do about it. Was surgery a success? How to make myself comfortable while resting.		
		Information was adequate probably more comprehensiv e than what is given at other medical facilities 22.		
Theme 2: Postoperative care at home. = **2**	1. Needed more information about what would happen when I got home.	1. Alternatives	1. Alternatives	1. Alternatives
		2. Needed more information about what would happen	2. I understand funding is limited, but it would have been good to	2. Needed more information about what would happen when I got home

		when I got home	get outside alternatives, possibilities. This is the only health care I have. I either do what the VA hospital says or I do without.	
			3. Needed more information about what would happen when I got home	
Theme 3: Bring any change of clothing or personal products = **1**	1. Bring any change of clothing or personal products	1. Bring any change of clothing or personal products.	1. Bring any change of clothing or personal products.	1. Bring any change of clothing or personal products.
Theme 4: Postoperative care/treatment at the CVAMC ER = **1**	1. I believe that they believe that there was such low chances of complications that after the follow-up call the next day no call again and it took ill the day after. I went to the ER and waited 6 hours before anyone could see me. If I had known that it is going to take that long, I would have gone to an outside	1. I understand funding is limited, but it would have been good to get outside alternatives, possibilities. This is the only health care I have. I either do what the VA hospital says or I do without	---	1. I believe that they believe that there was such low chances of complications that after the follow-up call the next day no call again and it took ill the day after. I went to the ER and waited 6 hours before anyone could see me. If I had known that it is going to take that long, I would have gone to an outside urgent care facility. Other than that, I think I received excellent pre and postoperative information and care

	urgent care facility. Other than that, I think I received excellent pre and postoperative information and care			
Theme 5: Discuss alternative treatments = **2**	1. Just wondering if I should have tried a different treatment. But the doctor did explain why surgery was needed	---	---	1. Just wondering if I should have tried a different treatment. But the doctor did explain why surgery was needed
				2. I understand funding is limited, but it would have been good to get outside alternatives, possibilities. This is the only health care I have. I either do what the VA hospital says or I do without
Theme 6: All information was adequate = **11**	1. Cannot think of anything to add 2. All was covered 3. I think they explained things very well 4. Everything was explained 5. The information was strongly agreed 6. The information I received was adequate	---	1. Cannot think of anything to add 2. All was covered 3. I think they explained things very well 4. I'm good 5. The information was strongly agreed. 6. I received all I needed. 7. I knew everything 8. I feel like I	1. Cannot think of anything to add 2. All was covered 3. I think they explained things very well 4. Everything was explained 5. The information was strongly agreed 6. The information I received was adequate 7. I received all I needed. 8. I knew everything. 9. I feel like I was prepared for postop care and I am very thankful to both the surgeons and the staff here 10. None that I am aware. 11. Information was

	7. I received all I needed. 8. I knew everything. 9. I feel like I was prepared for postop care and I am very thankful to both the surgeons and the staff here 10. None that I am aware. 11. Information was adequate probably more comprehensive than what is given at other medical facilities		was prepared for postop care and I am very thankful to both the surgeons and the staff here 9. None that I am aware. 10. Information was adequate probably more comprehensive than what is given at other medical facilities 11. I believe that they believe that there was such low chances of complications that after the follow-up call the next day no call again and it took ill the day after. I went to the ER and waited 6 hours before anyone could see me. If I had known that it is going to take that long, I would have gone to an outside urgent care facility. Other than that, I think I received excellent pre	adequate probably more comprehensive than what is given at other medical facilities

			and postoperative information and care???	
Survey Question #3: What other information do you think should have been addressed regarding your proposed surgery?	Evaluator #1	Evaluator #2	Evaluator #3	Final Analysis
Theme 1: Case management concerns = **5**	1. How likely it is the surgery will work.	1. That I would have results ASAP. I was told that biopsy results will be in 48 hours. I waited 8 days.	1. That I would have results ASAP. I was told that biopsy results will be in 48 hours. I waited 8 days.	1. That I would have results ASAP. I was told that biopsy results will be in 48 hours. I waited 8 days.
	2. That I would have results ASAP. I was told that biopsy results will be in 48 hours. I waited 8 days.	2. Blood clumps and how to remove them and how long after surgery I could start removing them	2 Give a sample of medicine or antibiotic to take with you.	2 Give a sample of medicine or antibiotic to take with you.
	3. Blood clumps and how to remove them and how long after surgery I could start removing them.	3. After effects of surgery	3. Medications when I went home.	3. Medications when I went home.
	4. Maybe if there would be after effects regarding my vision	4. I don't know enough to ask any other questions.	4. Be prepared to stay better than prepared to leave	4. Be prepared to stay better than prepared to leave
	5. How long till I can blow	5. Chances of alterations of	5. Why wait so long for	5. How to deal with the "packing". Those

	my nose again.	planned changes in procedure.	biopsy results.	surgeries need an overnight stay to calm the patient, in my opinion
	6. How to care for dry mouth or prevention of dry mouth	6. Give a sample of medicine or antibiotic to take with you.	6. How to deal with the "packing". Those surgeries need an overnight stay to calm the patient, in my opinion.	
	7. Medications when I went home	7. They gave me enough info.		
	8. Be prepared to stay better than prepared to leave.	8. How long till I can blow my nose again.		
	9. Why wait so long for biopsy results.	9. It was covered well prior to surgery.		
	10. How to deal with the "packing". Those surgeries need an overnight stay to calm the patient, in my opinion	10. Good job		
	11. The pain afterwards and how to deal with it	11. Everything was pretty much explained.		
	12. How long pain would be and what kind of pain	12. The benefits of removal on other conditions.		
		13. Medications when I went home.		
		14. Be prepared to stay better		

		than prepared to leave.		
		15. Everything was explained well		
		16. I'm good		
Theme 2: Postoperative complications, risks/benefits = 9	1. After effects of surgery.	1. Maybe if there would be after effects regarding my vision	1. Blood clumps and how to remove them and how long after surgery I could start removing them.	1. Blood clumps and how to remove them and how long after surgery I could start removing them.
	2. Chances of alterations of planned changes in procedure	2. How to care for dry mouth or prevention of dry mouth	2. After effects of surgery	2. After effects of surgery
	3. Give a sample of medicine or antibiotic to take with you.	3. Postoperative complications should be completely explained	3. Maybe if there would be after effects regarding my vision	3. Maybe if there would be after effects regarding my vision
	4. The benefits of removal on other condition		4. How long till I can blow my nose again.	4. How long till I can blow my nose again.
	5. Sides effects, if any		5. How to care for dry mouth or prevention of dry mouth.	5. How to care for dry mouth or prevention of dry mouth.
	6. Possible encouragement that although painful, this surgery can very well change your life. Just being able to breath is so wonderful.		6. Side effects, if any.	6. Side effects, if any.
	7. Postoperative complications		7. The pain afterwards and how to deal	7. The pain afterwards and how to deal with it.

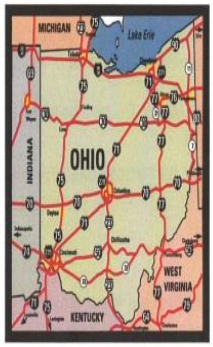
	should be completely explained		with it.	
			8. How long pain would be and what kind of pain.	8. How long pain would be and what kind of pain
			9. Postoperative complications should be completely explained	9. Postoperative complications should be completely explained
Theme 3: What is the success rate? **= 5**	1. Maybe estimate of success rate.	1. How likely it is the surgery will work?	1. How likely it is the surgery will work?	1. How likely it is the surgery will work?
		2. Maybe estimate of success	2. Maybe estimate of success rate.	2. Maybe estimate of success rate.
		3. Possible encouragement that although painful, this surgery can very well change your life. Just being able to breath is so wonderful.	3. Chances of alterations of planned changes in procedure	3. Chances of alterations of planned changes in procedure
			4. The benefits of removal on other conditions	4. The benefits of removal on other conditions
			5 Possible encouragements that although painful, this surgery can very well change your life. Just being able to breath is so wonderful.	5. Possible encouragement that although painful, this surgery can very well change your life. Just being able to breath is so wonderful.
Theme 5: I			1. I don't	1. I don't know enough to

don't know enough to ask information = **2**			know enough to ask any other questions.	ask any other questions.
			2. I understand the question, but I am not sure of a good answer.	2. I understand the question, but I am not sure of a good answer.
Theme 6: No information needs = **8**			1. They gave me enough information	1. They gave me enough information
			2. It was covered well prior to surgery	2. It was covered well prior to surgery
			3. Good job	3. Good job
			4. Everything was pretty much explained	4. Everything was pretty much explained
			5. Everything was explained	5. Everything was explained
			6. I'm good	6. I'm good
			7. I was well informed	7. I was well informed
			8. I feel everything was addressed.	8. I feel everything was addressed

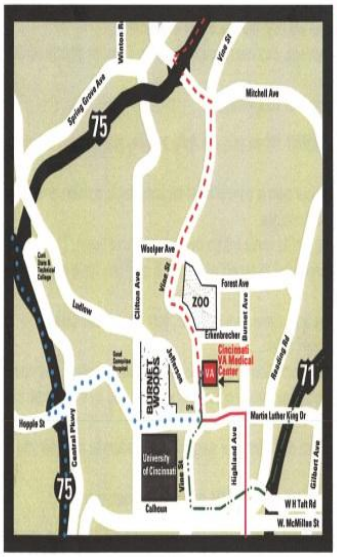
Appendix E:

Welcome to Surgical Service Brochure

Directions to CVAMC



The Department of Veterans Affairs Medical Center
3200 Vine Street
Cincinnati, Ohio 45220
(513) 861-3100



DIRECTIONS:

I-71 South:
- Exit on William Howard Taft (West)
- Continue straight on Taft
- Turn right onto Vine Street
- Continue on Vine past Martin Luther King Drive and the VA will appear on your right at the second light - turn right

I-71 North
- Exit Reading Road and go straight
- Continue till the road forks - you will fork off to the left onto
- Burnet Avenue
  Follow Burnet Avenue to Martin Luther King Drive
- Turn left onto Martin Luther King Drive
- Proceed straight to Vine Street where you will turn right
- The VA will be on the right at the second light - turn right

I-75 North and 74 East
- I-75 to Hopple Street Exit - East (left)
- Cross Central Parkway (go up the hill)
- You will pass Good Samaritan Hospital (on left) and go across Clifton Avenue. You are now on Martin Luther King Drive (Burnett Woods will be on your left)
- Continue up the next hill and turn left onto Vine Street
- At the second light turn right into the VA parking lot

I-75 South
- I-75 to Mitchell Exit (Exit 6)
- Turn left at end of ramp (you are now on Mitchell)
- The first street you come to where you can turn right is Vine Street (turn Right)
- Continue on Vine past the Zoo where the road forks stay right
- The VA Medical Center will be on your left - turn at next light

VA Healthcare System of Ohio

CINCINNATI

Welcome to Surgical Service

Welcome to the Surgical Service of the Cincinnati Veterans Affairs Medical Center! This pamphlet is a guideline for all surgical patients.

WHAT HAPPENS AT THE PRE-ADMISSION TESTING (PAT) APPOINTMENT? *Before your surgery, you will receive an appointment for Pre-admission Testing (PAT). Please allow 1-1 1/2 hours for your testing. You will:*

- Meet with the PAT Nurse. You will have blood and urine tests, and/or EKG and chest x-ray as needed.
- Meet with the Anesthesia Care Provider.
- Talk about the medicines you take. Bring a list of your medicines with you.
- If you are taking insulin for diabetes (sugar), you will be told how much and when to take it.
- If you take medicines for asthma, high blood pressure, seizures or heart disease these are very important and should be taken as directed up until the day of surgery unless you are told otherwise.
- If you take medicines such as aspirin, "blood thinners" or antidepressants you may need to stop them 7-10 days before surgery. You will be told what to do.
- If you take any of the following herbs, tell the PAT nurse:
  Ephedra, Ginkgo biloba, Licorice, Vitamin E, Feverfew, Ginseng, Senna, Garlic, Golden Seal, St. John's Wort, Ginger, Kava, Valerian

THE NIGHT BEFORE YOUR OPERATION: *Take two (2) separate showers, one in the morning and one in the evening. Be sure to wash and rinse your whole body. If you do not have a shower, you may wash at the sink. Be sure to wash all your skin.*

- Do not drink alcohol.
- Do not drink or eat anything after midnight (This includes water, candy, mints, gum, lozenges and chewing tobacco or snuff).
- Remove all jewelry, including ALL body piercing. Remove all metal from your body, including hair clips. Remove all nail polish.

THE DAY OF YOUR OPERATION: *Take one (1) shower the morning of your surgery. Be sure to wash and rinse your whole body. If you do not have a shower, you may wash at the sink. Be sure to wash all your skin.*

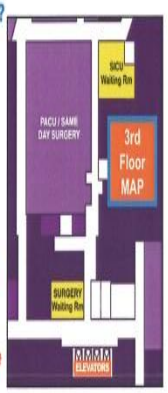
- You may brush your teeth, but do not swallow any water or mouthwash.
- If your Pre-Admission Testing (PAT) Nurse, Surgeon, Primary Care Physician, or Anesthesiologist told you to take any medicines, be sure to do this with only a "sip" of water.
- Dress in loose, comfortable clothing.
- Arrange for someone to drive you to the hospital and take you home after surgery and be available to help you. You will be unable to operate a motor vehicle for up to 24 hours after your surgery. Do not plan on signing any important papers or making any important decisions for up to 24 hours after your surgery. **BRING YOUR VA CARD.**
- If you are lodging at the hospital, be sure to bring your medicines.
- Do not bring your wallet, credit cards, valuables or insurance cards with you. Leave them at home or with your family.

WHERE DO I GO WHEN I COME TO THE HOSPITAL? *Enter the hospital through the side parking lot (Outpatient Clinic Entrance).*

- Take the main elevators to the 3rd floor. See map below).
- Go directly to the Family Waiting Room, B327 (left off the elevator).
- To report in, use the phone in the waiting room to call Same Day Surgery (SDS) at extension 6351.

WHERE DOES MY FAMILY WAIT WHILE I AM IN SURGERY?

- Your family will wait the Surgery Waiting Room, B327.
- The Health Unit Clerk in PACU will update your family about your status via telephone in the Surgery Waiting Room.
- About one hour after you leave the OR and come to the Peri-Anesthesia Care Unit (PACU/Recovery Room), the nurse will speak to your family.



WHEN CAN MY FAMILY VISIT ME? PACU VISITORS: *The PACU (Peri-Anesthesia Care Unit) is a recovery room for patients who have had special procedures or surgery. The patients in the PACU need time to rest. The doctors and nurses check the patients often and carefully. The space is small and we need to be sure that there is quiet and privacy for each patient.*

- If you wish to visit, please use the phone in the waiting room to call number 6351. Please do not come to the PACU before calling.
- Before the procedure or surgery, 2 people may visit the patient at a time.
- During the procedure or surgery, please try to have one family member stay in the waiting area during the procedure or surgery. The doctor will come to the waiting area to talk with you as soon as the procedure or surgery is done.
- After the procedure or surgery, 1 person may visit the patient at a time. The nurse will let you know how long you may visit. If the patient needs to be in the PACU longer than 6 hours, you may visit more often. We will call you anytime that the patient asks to see you.

There may be times when you are not allowed to visit:

- If the patient asks for "no visitors"
- If the nurse or doctor feels that the patient needs to rest
- If there is an emergency in the area

WHAT WILL HAPPEN IN THE PERI-OPERATIVE (PACU/RECOVERY) ROOM? *The staff from the Peri-operative Care Unit (PACU/ Recovery Room) will come to the waiting area to get you.*

- You will get a locker for your clothes. After you lock your locker, the key is taped with your name and kept in a secure place until after your surgery.
- You will change into a gown and put a covering on your head and feet.
- The nurse will ask you to verify your name, birth date, your surgeon's name, your scheduled operation, and if you have any allergies. We will also ask you to tell us which side is the correct side to be operated on, if a side applies to your surgery.
- The nurse will check your vital signs which include blood pressure (BP), pulse, respiration and oxygen level. You will have a temperature strip on your forehead.

WHY DO I HAVE TO COME IN SO EARLY? *Before your surgery or procedure, you will need time to:*

- Have your intravenous line (IV) started. You may get pre-operative medicines through your IV.
- Talk to the Anesthesia Care Provider again about the anesthesia that you will receive during the operation.
- Have many things checked before surgery.
- The surgery times may change. Early preparation will avoid any hurrying.

WHAT CAN I EXPECT IN THE OPERATING ROOM (OR)? *The Operating Room nurse and Anesthesia Provider will come to the PACU to greet you before taking you into the Operating Room.*

1. The nurse will ask you again to verify your name, your birth date, your surgeon's name and your scheduled operation including the correct operative side.
2. If you have glasses, contacts, and dentures, we will tag them with your name and social security number and put them in a safe place.
3. We will take you to the Operating Room by stretcher. The Operating Room is usually very cold and very bright. You will get warm blankets.
4. The nurse will put patches o n your chest to monitor your pulse, a blood pressure (BP) cuff on your arm to measure BP, and a plastic clip on your finger to measure your oxygen level.
5. You may have a mask on your face to give you oxygen.
6. You will get pre-operative medicine to help you feel calm and relaxed. This medicine will be given to you through your IV by the Anesthesia Care Provider.

WHAT CAN I EXPECT IN THE PACU AFTER MY SURGERY OR PROCEDURE? *The PACU nurses will:*

- Watch you closely and often.
- Check your vital signs every 10-15 minutes.
- Place oxygen by mask or through a small tube in your nose.
- Ask you to breathe deeply and cough. This helps to open your lungs and rid your body of the anesthesia gases.
- The PACU nurses will ask you to try to move your legs and feet up and down like you are pushing on the gas pedal of a car. This will help the blood flow in your legs.
- You may feel sleepiness, shivering, nausea, dizziness, headache, sore throat or muscle aches. These can be treated if troublesome.
- The surgeon will come to speak with you or your family.

IF YOU ARE TO BE DISCHARGED HOME? *When you are fully awake, you will get an appropriate diet and your IV will be stopped.*

- When your vital signs are stable and your pain is controlled at an acceptable comfort level, you will sit in a lounge chair for about 15-30 minutes.
- You will change into your clothes. The PACU nurse will go over your care at home. This includes medicines, care of any wound, what to expect and what to do if you have questions or problems at home.
- The nurse will give written instructions about your care at home, your filled prescriptions (medicines), and your return appointment date.
- Be sure that you understand all of the information you get. Please ask any questions you have.
- Your family will bring the car to the discharge area and the staff will take you by wheelchair to your car.
- One of the PACU nurses will call you the day after your surgery or procedure to ask how you are doing.
- You may have some of these problems during the first 24 hours after anesthesia: pain, headache, dizziness, nausea & vomiting, sleepiness, muscle aches and pains.
- You are **NOT TO DRIVE FOR 24 HOURS.** The medicines you received can impair your judgment, coordination and reaction time, making it unsafe to drive.

IF YOU ARE TO BE ADMITTED TO THE HOSPITAL? *The staff will tell your family to meet you in your room when you are transferred from the PACU.*

WHO DO I CALL IF I HAVE QUESTIONS AFTER BEING DISCHARGED TO HOME?

If you have any questions after you go home, you may contact the **PACU NURSE** at **513-475-6351**. After 6 p.m., call the main switchboard at **513-861-3100**, and ask for your doctor to be paged.To talk with the Surgical Staff, call **513-861-3100** and ask the operator for the service you need:

General Surgery - ext. 6400 or 6556, Orthopedic - Pager 019, Vascular - ext. 6400, Plastics - ext. 6400, Thoracic - ext. 6556, Eye - ext. 5311, Urology - Pager 052, ENT - Surgeon on-call, Neurosurgery - Pager 483-0050.

Curriculum Vitae

JONATHAN EDMUN M. RAMOS, RN, MSN

EDUCATION:

Present	WALDEN UNIVERSITY, DOCTOR OF EDUCATION - Student Focus: Higher Education and Adult Learning. Current GPA of 4.0
2005	UNIVERSITY OF CINCINNATI, COLLEGE OF NURSING Masters of Science in Nursing with concentration on Nursing Administration. Graduated with GPA of 3.91
2001	UNIVERSITY OF CINCINNATI, COLLEGE OF NURSING Bachelors of Science in Nursing. Graduated Magna Cum Laude with a GPA of 3.83.
1995	The Christ Hospital School of Nursing, Cincinnati, OH Diploma of Nursing
1987	CINCINNATI TECHNICAL COLLEGE, Cincinnati, OH AD Sales Marketing – Cum Laude with a GPA of 3.78
1985	FAR EASTERN UNIVERSITY, Manila, Philippines Bachelor of Science in Commerce major in Banking and Finance Received recognition as one of the Most Outstanding Students.

EXPERIENCE:

2004 - 2005	Patient Care Resource Manager - Ambulatory Care clinic Educated patients regarding daily weight monitoring and prevent frequency of CHF exacerbations. Compliance rate improved from 47% to 90% since CHF class was started. Piloted health buddy monitor system (Telehealth Medicine). Decreased use of Urgent Care/Emergency Room and frequent clinic visits since the launching of the program.
1998 – 2004	Staff Nurse – 5 South (Medical – Surgical Unit) Collaborated with Home Health and developed the Multidisciplinary Team Program (MET). This program decreased the length of stay of total joint patients in the hospital.