

**SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES
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**EXPLORATION OF SURGICAL PATIENTS' PERSPECTIVES OF PERI-
OPERATIVE NURSING CARE AT THE REGIONAL HOSPITAL,
BOLGATANGA**



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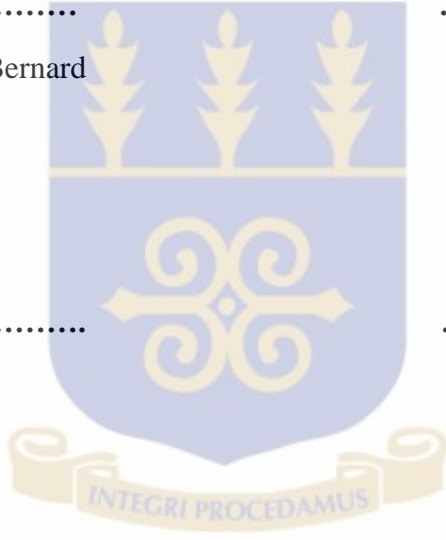
DECLARATION

I declare that this thesis is my own work that was produced from research under supervision. This thesis has not been submitted in any form for any degree or diploma at any university or other institution of tertiary education. Authors and Publishers whose work have been utilized in this study have been duly acknowledged in the text and list of references.

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DEDICATION

This thesis is dedicated to all patients seeking nursing care at the Regional Hospital, Bolgatanga. It is also dedicated to my family for their continuous support and prayers.



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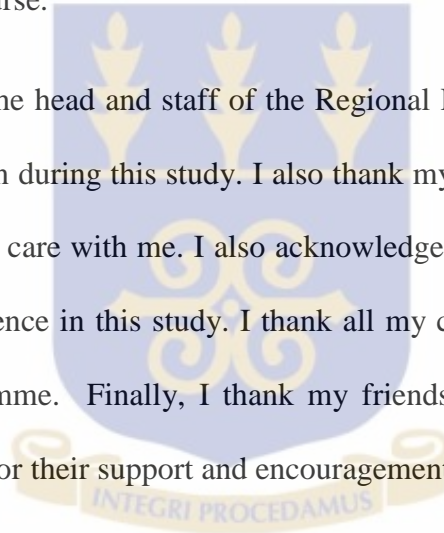


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LIST OF ABBREVIATIONS

AAGBI	Association of Anaesthetics of Great Britain and Ireland
AORN	Association of periOperative Registered Nurses
ASA	American Society of Anaesthesiologist
ECDC	European Center for Disease Control
ERAS	Enhanced Recovery After Surgery
GHS	Ghana Health Service
HPS	Health Protection Scotland
MOH	Ministry of Health
NICE	National Institute for Health and Clinical Excellence
PSH	Perioperative Surgical Home
RCN	Royal College of Nursing
TACS	Time of Acute Care Surgery
WHO	World Health Organisation

ABSTRACT

The purpose of this study was to explore surgical patients' perspective of perioperative nursing care at the Regional Hospital, Bolgatanga. The study was guided by Perioperative Surgical Home (PSH) as Microsystems health care model. The study employed a qualitative explorative descriptive design. Purposive sampling technique was used to recruit participants. The data was saturated with 15 participants aged between 23 and 65 years. All the interviews were audio-taped and transcribed verbatim. Data was analysed using the principles of thematic content analysis. Three major themes emerged from the study: preoperative perspectives, intraoperative perspectives and postoperative perspectives of care. These themes were consistent with the PSH Model. Also, additional theme that emerged was faith in God. Nurses helped to assess and triage patients to identify specific cases for urgent surgery. Nurses provided reassurance, counseling and prehabilitation and physical care to patients but failed to take patients' medical history. Nurses contributed effectively to ensure patients' safety and performed infection prevention to some extent during surgery but poorly managed patients' pain. Some patients sustained minor injuries as a result of poor usage of theatre equipments. Nurses provided inadequate information to patients throughout the perioperative period. Nurses exhibited poor communication attitude toward patients and poorly managed their wounds resulting in wound infection. Also, patients encountered high cost of care and nurses failed to visit patients at home after discharge. It was recommended that health care providers should involve patients in planning care. They should conduct physical assessment and review items used in the theatre.

CHAPTER ONE

1.0 Background

Perioperative nursing is a term used to describe a variety of nursing functions associated with the surgical experience. It comprises three phases of the surgical experience: preoperative, intraoperative and postoperative. Each phase begins and ends at a particular point in the sequence of events that constitute the surgical experience (AORN, 2012a). Each phase comprises a wide range of activities that the nurse performs using the nursing process based on standard practices (Spry, 2005).

Preoperative phase is an important phase because most of the patients are vulnerable in their needs both psychological and physiological. The important factor is anxiety due to fear of the unknown of the outcome of the surgery, pain and even death. Hence, the care should include physical, emotional preparation, guidance, assessment and possible referral to experts to promote recovery and prevent postoperative complications (Rosen, Svensson, & Nilsson, 2008). Also, patients should be evaluated for their preparedness for the surgery, identify potential risk of the patients, advice the patient about the surgical procedure and be prepared for postoperative experience and possibly plan with the patients for home care (Pearson & Osbom, 2010).

In surgery, it is important for patients to go into the theatre fully prepared physically and emotionally before surgery is done (Bruce, 2001). Surgical patients go through either planned (elective) or emergency surgery. In the planned surgeries, surgical patients go through a multidisciplinary team of experts' examination depending on the patient's condition. These experts include the nurse, the anesthetist, the surgeon, the clinical psychologist, laboratory technician and the radiologist among others. The anesthetist assesses the patients and informs them of what is expected of them. In case of any abnormalities the patients are referred to the doctor for management (Aziato &

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Adejumo, 2013). In emergency surgery, the patients do not go through anesthesiologist assessment clinic and the range of the nursing care varies depending on the urgency of the surgery, existence of disease condition and available facilities (Aziato & Adejumo, 2013). Hence surgical patients are often prepared adequately and depending on the condition and age of the patient; the patient is starved for at least 6-8 hours before the surgery (Brady, Kinn, Ness, & Stuart, 2010).

A study conducted in the Western Santa Catarina using a qualitative design, indicated that most patients expressed feeling of insecurity, fear and nervousness prior to surgery. However, nursing care such as physical preparation, guidance to minimize the risk of postoperative complication and psychological approach such as adequate information delivery were rarely performed during preoperative phase. Patients also expressed inconsistency of the care. Some patients said nurses contributed positively during preoperative phase to help them go through the surgery with little fear whilst others were of the view that nurses did not help them at all (Ascaria, Noiss, & Sartori, 2013).

Further studies conducted in Ghana showed that, patients are always afraid of the surgery due to the pain associated with it, possible infection and bleeding that may occur. It is also reported that some patients even lost their lives while undergoing the surgery (Badoe, 2009). Hence adequate information should be given to patients during preoperative phase to reduce anxiety and also enhance postoperative recovery (Aziato & Adejumo, 2013b; Guo, East & Arthur 2012).

A study in the United State of America stated that, during the intra-operative phase, the patient is usually drowsy due to the preoperative medications but is aware of what is happening to him. Therefore patients should be reassured not only verbally but nonverbally by facial expression, a touch or a warm grasp of the patient's hand to relieve their anxiety. It further stated that the patient should never be left alone until the

surgery begins (Bruce, 2001). However, a qualitative study conducted in Korle-Bu and Ridge hospital in Ghana, using a semi-structured interview questionnaire, indicated that patients often experienced fear when they are in the theatre. The patients become afraid when they see the other patients being brought in and out of the theatre. They wish that they were informed of what is expected of them in the theatre before they enter to help reduce their fear (Aziato & Adejumo, 2013).

A quantitative study conducted in Pakistan indicated that postoperative complication is a disturbing phenomenon in the Teaching Hospital of Karachi. It was observed that 29.6% of surgically operated patients had complications. The common complications observed were postoperative pyrexia in (18.2%) patients followed by postoperative nausea and vomiting in (11.6%) patients, wound infection in (11.4%) patients and respiratory tract infection in (7.0%) patients. These complications occurred due to poor preoperative assessment, poor surgical technique and postoperative care and lack of proper follow up care. In line with this, another study showed that patients complained that they were not informed of all possible risk, not advised on what to expect in the postoperative period and were not educated on early recognition and reporting of adverse events in order to prevent these complications (Masood, Syed & Zubia, 2006).

Postoperative symptoms can be disturbing and this causes the delay in patient return to daily life function. The common symptoms that patients complained of are pain, nausea, drowsiness, tiredness, fatigue and dizziness (Chung & Schnaider, 2006; Rosen, Clabo lanzon & Martensson, 2009). Also, patients often deal with psychological postoperative problems such as mood swings and anxiety due to the changes in the body image like swelling and discolouration of the incised site. The patients therefore stated that they expect nurses to care for them after surgery in order to facilitate their recovery (Demir, Dimamali, Donmez, & Ozsaker, 2008; Mitchell, 2010). However, a study conducted in

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Kenya hospitals showed that, patients at the surgical ward were not satisfied during postoperative nursing care. They said nurses were rude, impolite and feel reluctant to attend to them (Ojwang, Ogutu, & Mata, 2010).

Adequate assessment of surgical patients is important before discharge. In a study conducted in USA, 1442 patients were operated between 2009 and 2011 and 11.3% of these patients were readmitted to the hospital within 30 days of discharge due to poor assessment during discharge planning (Sweeney et al, 2013). Postoperative complications were the significant independent risk factor leading to the readmission. Patients who had one or more complications after their surgery were four times more likely to be readmitted to the hospital compared with those who had no complications (Sweeney et al, 2013).

Majority of the surgical patients interviewed in another study complained that they were not informed about what to do when they were discharged home and that affected their care at home resulting in some of them developing complications (McDonald, Siegmeth, Deakin, Kinninmonth & Scott, 2011). Due to this, further studies indicated that surgical patients should be prepared for discharge and failure to do so may result in patients being discharged home with uncertainty about their care. Besides, it is important to provide adequate information and discharge planning for surgical patients based on their postoperative needs especially information on postoperative recovery and self care at home (McMurray, Johnson, Wallis, Patterson, & Griffiths, 2007). From the above studies, it is evident that studies have either explored preoperative or post-operative nursing care with little having been done on perioperative nursing care. The study adopted the Perioperative Surgical Home model as a healthcare Microsystems model adapted by Kash et al, 2013 to guide the study.

1.1 Statement of the problem

In Bolgatanga Regional Hospital, statistics indicated that from 2011-2012, the hospital recorded a total of 2,595 surgical patients for operations ranging from elective to emergency surgeries. With this number, 649 (25%) patients developed complications such as wound infection. Five percent (5%) of these patients were readmitted at the Hospital. These statistics presupposes that there may be a problem with the nursing care that needs to be investigated. The Regional Hospital's Quality Assurance Team conducted a survey in 2012 on nursing care at the surgical wards and it was revealed that 87.7% of the respondents on the wards were not satisfied with the care rendered to them (Annual Report; Regional Hospital, 2013). The researcher's personal experiences during the monitoring of his students on clinical placement indicated that surgical patients often complained of long queues and waiting time for the nurses to attend to them especially when they come for wound dressing. The researcher also realized that majority of the out patients wounds were infected.

A qualitative study conducted in Malawi to assess patients perception of care, indicated that patients want nurses to respect them, and treat them with kindness and dignity instead of the bad experiences they encounter with nurses during their stay on the ward (Kumbani, 2012).

A review of literature shows that it seems there is lack of research on the perspectives of surgical patients on perioperative nursing care at the Regional Hospital, Bolgatanga. The study therefore seeks to explore surgical patients' perspectives on perioperative nursing care at the Regional Hospital, Bolgatanga.

1.2 Purpose of the study

The study aims at exploring surgical patients' perspectives of perioperative nursing care at the Regional Hospital, Bolgatanga.

1.3 Objectives of the study

The main objective is to explore surgical patients' perspectives on perioperative nursing care.

Specific objectives will be to;

1. Explore surgical patients' perspectives on preoperative care
2. Explore surgical patients' perspectives on intraoperative care.
3. Investigate surgical patients' perspective on postoperative care and discharge planning.

1.4 Research Questions

1. What are the surgical patients' perspectives of preoperative nursing care at surgical ward?
2. What are the surgical patients' perspectives of intraoperative nursing care at surgical ward?
3. What are the surgical patients' perspectives of postoperative nursing care at surgical ward and discharge planning?

1.5 Significance of the study

The study will provide nurse managers at the hospital an insight about the gaps in nursing care for planning training needs of nurses. It will also provide information to the hospital management especially the nursing department for future policy implementation. The research findings will help contribute knowledge to the nursing. The research will provide the public health nurse insight into surgical patients' needs at home.

1.6 Operational Definition of Terms

Surgical patients: These refer to patients who have had operation (emergency and planned) and have been discharged from the Bolgatanga Regional Hospital. It also includes patients who have stayed in the surgical ward for five days or more.

Patients' perspectives: These refer to patients' views on perioperative nursing care.

Peri-operative nursing care: This refers to the nursing care rendered to patients before (preoperative), during (intra-operative) and after operation (postoperative) including discharge planning.

CHAPTER TWO**LITERATURE REVIEW****2.1 Introduction**

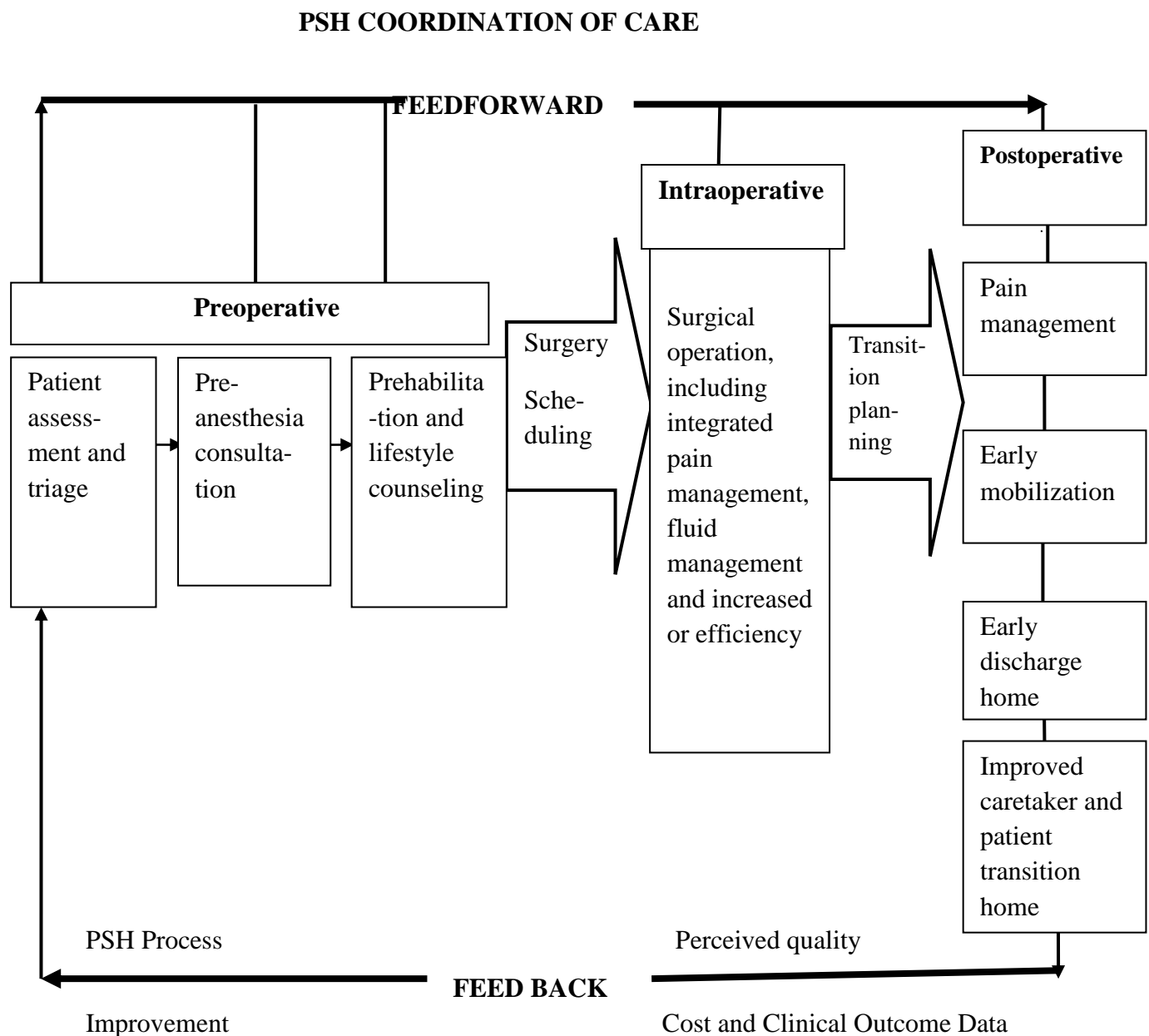
A critical review of research about the surgical patients' perspectives of perioperative nursing care shows that there have been limited studies on perioperative nursing care, especially within the Ghanaian society. The review of literature for the study is focused on the theoretical framework guiding the study, patients' perspectives of preoperative nursing care, patients' perspectives of intraoperative nursing care and patients' perspectives of postoperative nursing care including discharge planning.

The researcher searched the electronic database such as "Scencedirect", "Google Scholar", and 'Sage' among others of the University of Ghana database using the key words 'nursing models', 'nursing theory', 'conceptual framework' to get a theory, model or conceptual framework that will guide the study. In search of a theory, a number of models, theories and conceptual framework such as Rush Medicus Tool developed by Hus et al., 2002, Healthcare Microsystems model developed by Nelson et al., 2011, Perioperative Surgical Home Model developed by the American Society of Anesthesiology (ASA, 2013), and Perioperative Surgical Home as a Microsystems adapted from Nelson et al (2011) by Kash, et al, (2013) were identified. A critical review of these models and frameworks showed that the adapted Perioperative Surgical Home (PSH) as a Microsystems Health care Model would be applicable for this study. The models' constructs reflect the phases of perioperative nursing care as compare to the rest of the models discovered. Besides, the PSH model has been used much in explorative researches to solicit patients' views in various fields even though it can be used in quantitative research too. Also, the PSH model examines patients care through perioperative period to include home care and their perceptions of the quality of nursing care they received during their hospital stay. Based on these reasons, PSH model is best

suiting for the study since the researcher aims at exploring the perspectives of surgical patients on perioperative nursing care including home care.

2.2 Theoretical Framework

The theoretical framework that guides the study is Perioperative Surgical Home as Microsystems Model developed by Nelson et al, (2011) and adapted by Kash et al, (2013). The aim of PSH Model is to achieve triple aim of better health, better health care and reduce cost through continuous improvement for all patients undergoing surgery. The PSH is a physician led multidisciplinary team based system of coordinated care which guides the surgical patients through the entire surgical experience from the decision for the need for surgery to discharge from a medical facility and beyond. Figure 1 shows the framework of the model.

Figure 1: PSH as a Microsystems Healthcare

Source: Adapted from Nelson et al, (2011)

The development of the Perioperative Surgical Home as Microsystems Model occurred by integrating the concept of Perioperative Surgical Home into the Clinical Microsystems Model developed by Nelson et al, (2011).

Clinical Microsystems are places where patients, families and caregivers meet for health care services and where outcomes and costs are produced. It integrates patient process and resources planning and health outcomes through continuous assessment and

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improvement of care (Nelson et al., 2011; Samiei et al, 2011). The Clinical Microsystems have feed-forward and feedback information which makes it more valuable to its functions. The feed-forward information collects data during the time that the care is delivered and this data is being used with the patient in an understandable way throughout the patient's healthcare experience (Nelson et al., 2011). The feedback information is used for prospective management of patients in future care episodes, evaluation and management of individual care. It allows simultaneously, individual level data to be accumulated into subpopulation of similar patients to use as a database for evidence-based practice (Nelson et al., 2011).

The processes in Clinical Microsystems includes; patient orientation to the healthcare system, provider making an initial health assessment to create a plan of care that incorporate the patient's health status, health needs, and individual health preferences (Eugene, 2013). This step builds up feed-forward information from prior healthcare experiences, patient history, physical examination and diagnostic testing. Besides, there is a constant assessment of surgical patients to help minimize error in patient care (Knox, Myers, Wilson & Hurley 2009; Nelson et al, 2011, Samiei et al 2011). The patient care plan is created to include all preventive, acute, chronic and palliative care based on the findings of the previous assessment. Also longitudinal measures are collected to assess the patient's clinical status, functional status, patient perceptions of care as well as direct and indirect cost tracking. These measures are also used to improve future care for that patient and other patients (Nelson et al., 2011.

Tregunno, 2013).

Based on the assumptions of the Clinical Microsystem, the Perioperative Surgical Home developed by the American Society of Anaesthesiology (2013) fits the definition of the healthcare Microsystems. The PSH is also a place where care is planned,

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delivered and managed, and outcomes are achieved with various providers such as nurses, physicians, anaesthetists among others meeting patients and family members (Kash et al., 2013). The Clinical Microsystems theory also suggests integrated information management system to be essential in the development of the PSH hence the development of the Perioperative Surgical Home as Microsystem Models. The adapted PSH as healthcare Microsystems model by Kash et al, (2013) is appropriate for this study.

The main constructs which formed the feed forward information of the model include Preoperative care which comprises; patient assessment and triage to identify patients that need preadmission clinic or program, preanaesthesia consultation, prehabilitation and lifestyle counseling. Intraoperative care where there is surgical operation, including integrated pain management, fluid management and increase or efficiency of care which included patient safety, prevention of infection and information and communication. Postoperative care which included pain management, early mobilization through physical therapy and integrated acute-care and rehabilitation care, early discharge home by improving coordination of care from preoperative to discharge home. It also involves nurses improving caretaker and patient transition home by increasing patient and caretaker education concerning post-discharge care. The feed back formation which is part of the postoperative care includes the patients' perception about the quality of care received. This deals with patients' clinical outcome as well as patients' cost tracking with possible improvements for future care.

The researcher is applying the entire Perioperative Surgical Home (PSH) Model as Microsystems constructs including patients' perception of quality of care to guide the study. The model would guide the researcher to explore participants' perspectives on preoperative care on patient assessment in areas such as, vital signs, laboratory and

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radiological examinations, pre-anaesthetic consultation and prehabilitation and lifestyle counseling to improve participants' recovery and prevention of postoperative complications. Also the researcher would use the model to explore participants' perspectives on integrated pain management, fluid management, infection prevention and how the participants' safety was ensured during the operation. The researcher also explores surgical participants' perspectives on postoperative pain management; early mobilization to increase participants' recovery, and how early discharge home planning can improved participants efficiency and effectiveness to care for themselves at home. Feedback information would be solicited from participants on how they perceive the quality of care given in terms of clinical outcome, cost of care including care areas that need improvement.

The PSH model used in a study to assess pre-habilitation counseling of patients before surgery indicated that, pre-habilitation counseling reduces postoperative complications and also increases patients' ability to mobility and functional task performance (Nielsen, et al., 2010; Swank et al., 2011). This confirmed the survey conducted at Bolgatanga Regional Hospital where about 25% of the surgical patients were readmitted to the ward due to infection after surgery. It may be due to the fact that these patients did not receive pre-habilitation counseling before the surgery. Besides, the assessment of patients' readiness for surgery using the model in a quantitative study in areas such as risk based on age, co- morbidities and functional capacity before surgery, shows that it has greater impact on patients' improvement after surgery (Mythen, 2011). This also shows that assessing patients before surgery is very important hence the model is used as guide to solicit patients' views on their assessment before surgery by using qualitative exploratory descriptive approach.

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A study conducted in seven hospitals in Western Europe using Perioperative Surgical Home Model indicated that increasing intraoperative fluid management improves patients' health condition after surgery (Knott, et al., 2012). It further indicated that restricting the intake of fluids before surgery has 95% chance of patients having a longer period to recover after operation. However, patients who are allowed to take in clear fluid on day of operation and whose Foley's catheters are discontinued early have 95% chance of being discharged home early (Aarts, et al., 2012). Contrary to this findings, a study conducted in USA to determine the effect of intraoperative fluid management on outcome after intraabdominal surgery involving 157 patients in which 75 patients were given liberal fluid and 77 patients were restricted in their fluid intake indicated that patients whose fluid intake was restricted had fewer postoperative morbidity and short hospital stay as compared to the patients who took the fluid before the surgery (Nisanevich, Felsenstein, & Almongy, 2005). However, the study failed to justify how fluid management enhances speedy recovery in surgical patients. The study did not also point out the types of surgical cases that require this form of regimen and therefore may not be applicable to the African cultural context.

A meta-analysis of postoperative care of patients using the model as a guide revealed that patient's lifestyle has both positive and negative effects on surgical recovery. It is stated that patients who stop smoking for more than four weeks before surgery have lower risk of respiratory complications by 23%, eight weeks has 47% and more than eight weeks is comparable to non-smokers risk. Also patients who stop smoking for three to four weeks before surgery showed a higher reduction of wound healing complications (Wong, et al., 2012). However, Leichtle et al., (2012), in their study at Michigan on surgical quality, indicated that wound infection is due to contamination of the wound. This shows that educating patients on the need to change their lifestyle

especially smoking is very important, hence, the study would add more knowledge to previous studies.

Discharge planning with the patient and family members is an effective measure for speedy recovery of patients at home. Studies that use PSH model as a guide have shown that, inadequate discharge teaching time, inability of family members to meet post discharge needs and poor continuity of care at home affect patients' recovery leading to readmission due to complications, bowel disturbance, nausea and extreme anxiety in patients (Wennström et al., 2010). Also, a study at Tertiary Care Hospital in Brisbane, showed that improper discharge planning results in patients' experiencing pain, heightened body awareness and lifestyle adjustment problems that need support from the nurses (Theobald, Karen, McMurray & Anne 2004).

The researcher sent an Email to the model developers (bakash@srph.tamhsc.edu) informing them the researchers' decision to apply the model to the study but there has not been a response.

2.3 Surgical Patients' Perspectives on Preoperative care

A qualitative study conducted on patients' assessment indicated that preoperative history taking and physical examination is concerned with obtaining information directly from the patient (Bohmer, Wappler, & Zwissler, 2014). Also, about 25.7% of anaesthesiologists surveyed confirmed that they performed regular history and physical examination of surgical patients to obtain baseline information from patients prior to surgery. Further studies have indicated that the purpose of this history taking and physical examinations were to identify patients with high risk that could have an adverse effect on the forthcoming surgery and perioperative care. It focused on the indication for surgical procedure, allergies, undesirable side-effect to medication and possible referral for correction (AAGBI, 2010; Akhtar, MacFarlane, & Waseem, 2013).

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Further studies have shown that when clinicians thoroughly assess surgical patients' condition and examine them physically it helps to identify and correct any abnormality before surgery (Aziato & Adejumo, 2013; Aditya & Uma, 2011). However, another study has indicated that sometimes, patients' history and physical examination during assessment may be hindered by patients' expression of pain which make them uncooperative (Aziato & Adejumo, 2014c). According to the Ghana Patients' Charter, patients have the right to certain information such as confidential information obtained about them and right to privacy during consultation, examination and treatment (Ghana Health Service, 2002). As a result, it is important that during such nursing procedure, patients' comfort and dignity must be maintained through the provision of privacy (NICE, 2008).

Preoperatively, routine laboratory investigations are performed to assess whether patients have pre-existing health problems or any medical condition unknown to the patients. It would also help to predict post-operative complication and also establish a reference point for comparison (Garcia-Miguel, Lopez-Bastida, & Serrano-Aguilar, 2003). Moreover, investigation will also guide the decision of implementing protocol such as fasting and administration of regular medication (AAGBI, 2010). A qualitative study conducted at Korle-bu Teaching Hospital in Ghana on preoperative experience among 13 patients, showed that surgical patients went through some preoperative preparation such as laboratory and radiological investigations. It was reported that health professionals such as nurses, doctors, and the anaesthetists were involved in preoperative care. Hence, the anaesthetists assessed patients and declared them fit for the surgery (Aziato & Adejumo, 2013).

Besides, studies have indicated that nurses do monitor surgical patients' vital signs and any abnormal reading are reported for possible correction before surgery (Aziato &

Adejumo, 2013, NICE, 2008). This confirms a study that showed that preoperatively, nurses monitored surgical patients conditions and identify medical risk factors to promote health and optimize patients condition (Verma, Alladi & Jackson, 2011).

A qualitative study conducted at Pakistan University teaching Hospital among 28 surgical patients, found that nurses and other healthcare providers performed a complete and thorough assessment of surgical patients. They provided them with adequate education on surgery to reduce bounce back rate from operating room and to avoid any risk (Barkat, Lalani, & Malik, 2012, Cathy, 2013). Apart from that, provision of adequate education to patients and their relatives would help them to understand the nature and the consequences of any proposed procedure prior to giving informed consent (AAGBI,2010; Crawford, 2012; Babitu & Cyna, 2010,). Also patients who have learning or mental disability and cannot consent, including children should have their relatives present and be given written information so that consent, capacity and reasonable adjustment can be discussed (Cathy, 2013).

Fraczyk and Godfrey, (2010), in a study of 275 participants, indicated that 80% of the patients undergoing the surgery seem to be highly motivated to change their lifestyle when they were informed about the increasing rate of complications associated with smoking, alcohol drinking and overweight before surgery. This shows that if nurses focus their assessment on medical investigations during preoperative assessment without assessing patients' lifestyle, it may also have an impact on the patient surgical outcome.

A study conducted by world society of emergency surgery group initiate on Timing of Acute Care Surgery classification (TACS) including other study indicates that, patients triage should be used during assessment as a base of prioritizing patient's management. Patients are triaged according to the severity of the patients' disease process and clinical

outcome rather than age. It is a process that ensures that proper care in a timely manner is given to the sickest (Abularrage, Crawford & Cambria, 2010; Kluger, et al, 2013). For instance, (Papandria et al., 2012) indicate that a delay in surgical treatment for patients with acute appendicitis is associated with increase perforation rate in both children and adults. The finding suggests that patients' assessment and triage should be done early enough to identify patients that need emergency treatment in order to prevent complications. Hence the study would add more knowledge to this aspect of care.

Studies have indicated that effective information delivery to surgical patients has an empowering effect that enables them to take control over their health care and to comply with treatment. It lets the patients understand whatever is expected of them (Leino-Kilpi & Suhonen, 2006; Mulsow, Feeley, & Tierney, 2012). However, patients' level of understanding is an important factor that should be assessed before educating them. This will help nurses to manage patient's stress and anxiety during education. It will also help the nurses to find out ways of reducing risk such as pressure ulcer, venous thromboembolism and malnutrition. Inadequate education and information increases patient anxiety, inability to cope and planning for discharge (Rhodes, Gail, & Alan, 2006).

In a study at a University Hospital in Germany using a quantitative method, with a sample size of 461 surgical patients, 106 of them viewed staff friendliness, professionalism and good interpersonal communication during pre-anaesthetic consultation to be helpful in reducing their surgical concerns such as fear and anxiety (Schnoor, Ulrike, Engelmann, & Burkhardt, 2013). For instance, in Sweden where six patients were interviewed on their experiences of care, it was indicated that, patients expressed fear about the surgery due to anaesthesia, paralysis or severe pain after surgery and therefore express the desire for pre-anaesthetic counseling before surgery

(Anna-Clara, et al, 2010)). This confirms a qualitative study conducted by Mavridou., Dimitriou, Manataki, Arnaoutoglou, & Papadopoulos, (2013) among 12 patients that revealed that pre-anaesthetic consultaion reduce these concerns by 60% . However, a descriptive cross-sectional study conducted at the surgical unit of two hospitals in Ponta Grossa revealed that, nurses provide only physical care to patients with little information about the surgical procedure and nursing care delivery. This created more fear and anxiety among the patients (Bouwman & Carvalho, 2009).

In a quantitative study at a South Australia tertiary Hospital, it was found that out of 416 participants, about half of the participants (45%) failed to understand the terms used during pre-anaesthetic consultation. The anaesthetist used terms such as 'reflux', 'aspiration', 'allergy' among others that the patients never understood (Babitu & Cyna, 2010). As a result, it is expected that nurses use simple language during consultation for the patients to understand (Fields, Freiberg, Fickenscher, & Shelley, 2008). This can be generalized since the sample size is large to indicate that nurses used technical language that the patients did not understand. It therefore shows that patients go in for the surgery without adequate prior information. However, this finding may be different in a different cultural setting.

A study conducted in Ghana using qualitative approach of 13 patients, indicated that surgical patients did not receive adequate information about their surgery and subsequent care especially preoperative care and their expectation in the theatre during pre-anaesthetic consultations (Aziato & Adejumo,2013). This has been confirmed by a study that stated that nurses did not inform surgical patients of what will happen. The patients stated that only the medical officer told them that they were going to be operated without any pre-anaesthetic consultation (Berg, Arestedt & Kjellgren 2013). However, further study conducted to understand the patients perspective of emotional support to improve overall patient satisfaction indicated that information to patient

about their treatment plan, diagnosis, procedures and prognosis help to reduce patients anxiety and worries (Adamson et al., 2012).

Also, some patients admitted that nursing care has contributed positively to their ability to go through surgery and for some patients nursing care was absent making them more afraid. Some patients mentioned that they received information whilst they were lying on the operating table waiting for the anaesthesia to start (Igna, Monika, Kerstin, & Kaety, 2011). Hence, since each patient is unique and has unique characteristics it is important to establish effective communication with patient and significant others during pre-admission contact. This will provide an opportunity for the patients to obtain relevant and specific information and education to enable them go through the surgery (Rhodes et al., 2006). Apart from this, nursing staff may also rely on patient information that will enhance an individualized care and guidance in the preoperative period to promote physical and psychological preparation of the surgical patients for the surgery (Ascari, Neiss, & Sartori, 2012).

Also studies indicated that providing appropriate support such as orientation of patients to ward environment and advice that is easily accessible for those patients that need it are key areas for improvement during preoperative period (Rachel, Davis, Charles, Ania, & Alison, 2011). Further studies indicated that allowing patients and their relatives to familiarize themselves with the environment through orientation and to meet staff who will provide perioperative care or a visit of nurses to ward may relieve patients' anxiety and answer patients' questions relating to anaesthesia and surgical process(Crawford, 2012).

Maintenance of personal hygiene before surgery is very vital in preventing infection. The European Center for Disease Control (ECDC) in a study estimated that 4.1 million patients per year develop infection within the European Union as a result of poor health

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care and that 37,000 death results annually due to such infection (WHO, 2011). It is therefore important that surgical patients shower using soap and water the evening before surgery. Practicing personal hygiene provides the framework for achieving quality nursing care and also indicates nurses contributions to improving health care outcome (Currie, et al 2011). Also, the removal of hair around the incision site where necessary, should be done on the day of surgery. Patients that have been prepared for surgery should remove the pants, brassier, jewellery, earrings, dentures and this should be done in a manner that patient comfort and dignity is maintained (NICE, 2008). According to Snowdo, Haines, & Skinner, (2014), it is important that nurses educate surgical patients on the importance of deep breathing and coughing, regular gentle leg exercise and early mobilization. This would reduce patients' risk of postoperative complications such as chest infection and deep vein thrombosis.

Physiologically, it is recommended that surgical patients should not take food the night before the surgery the following day. However, patients could be given clear fluid up to two hours and food up to six hours before surgery since fasting can be difficult to manage when the operation can be cancelled or delayed (Royal College of Nursing, 2010; Crawford, 2012). Further study revealed that shortening fluid fasting time leads to less anxiety preoperatively and also less nausea and vomiting postoperatively. Hence, liberal fasting regimen such as drinking clear fluid until two hours before elective surgery, increases patient comfort and satisfaction with anaesthesia (Ian et al, 2011; Bopp et al., 2011). These studies therefore suggest that the overnight routine fasting is gradually coming to end in most modern medical societies (Anguilar-Nascimento & Dock-Nascimento, 2010). Also prescribed preoperative medications should be given to patients and only essential medicine should be given with those that need to be taken orally given with little water. It is stated that preoperative medications help to relieve

patients' anxiety, pain, prevent nausea and vomiting, and reduces aspiration (NICE, 2008; Crawford, 2012).

Prolonged waiting time for surgery often creates fear and panic in patients. Also, studies have indicated that there are many factors that contribute to surgical patients developing anxiety. These may include fear of anaesthetic effect, the procedure itself and the potential outcome of the surgery (Degen, Christen, Rovo & Gratwohl, 2010). Besides, since some patients may not have experienced surgery before it could create more fear and anxiety in them (Tessa, Alison & Wiseman, 2014). It is therefore argued that perhaps the relatives of the patients should be allowed to sit with the patients before the surgery to help reduce patients' anxiety (Cathy, 2013; Pritchard, 2009b; Rhodes et al., 2006).

It is indicated that during perioperative care, most patients wish that nurses recognize their religious background and incorporate it into the care process (Jan, et al, 2012). A qualitative study conducted in Akwa Ibom State of Nigeria, to assess the relevance of religion in health care among 560 participants in both public and government hospitals indicated that, patients have faith in God and combined prayers with medicine. These patients often pray alone or with their family members or call the spiritual leaders to pray for them. Besides, the medical officers also recognizing the importance of religion in care, advised patients to seek spiritual help through prayers (Abiodun & Umoh, 2011). Also in our Ghanaian culture, especially in the indigenous societies, the spiritual world is often consulted for different purposes in which one aim is the attainment of good health. As a result people often consult the diviners and the soothsayers for good health (Azongo & Adadow, 2015; Adadow, Rothenburg, Sackmann, & Thompson, 2014). This confirms a qualitative study conducted by Aziato & Adejumo, (2014a) at Korle-bu Teaching Hospital, Ghana, to assess the psychological factors associated with

pain in which family members recognized the need for spirituality, prayed for their relatives to go through surgery and recover successfully. These studies stress the importance of religion to the health care delivery systems in Ghana. Hence it is expected that health professionals, especially nurses, attach seriousness to patients' religion during care and respect them.

2.4 Surgical patients' perspective on intraoperative care

According to the Association of periOperative Registered Nurses AORN, (2012a), intraoperative period begins when the surgical patient is transferred to the operating table and ends with the transfer of the patient to the Postanaesthesia Care Unit or in an area where immediate postsurgical recovery care is given. However, Antipuesto,(2011) argued that intraoperative phase extends from the time the patient is admitted to the operating room to the time that anaesthesia is administered, followed by surgical procedure and continues when the client is transported to the recovery room or the Postanaesthesia Care Unit. Based on these two schools of thoughts of intraoperative period, the researcher reviewed literature on patients' perspectives of intraoperative care to include patients that are sent to the operating room and not necessarily on the operating table. The review will also be extended to the recovery room or Postanaesthesia Care Unit.

During the intraoperative phase, nurses need to assess the patient to identify signs of anxiety such as restlessness, raised vital signs, nausea and heightened senses or psychological problems. Besides, surgical patients' blood pressure, pulse, respiration, temperature, oxygen saturation are monitored and recorded accurately in the theatre before and during surgery (Pritchard, 2009b; Cathy, 2013).

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In a retrospective study in the USA involving 26 surgical patients using qualitative method, it indicated that patients' perspective of care reflects in nurses demonstrating understanding, confidence, and commitment and respect during the surgery (Tinnfalt & Nilsson, 2011). They should also improve on patients participation, pain management, reduction of anxiety and proper positioning during surgery to avoid pressure sores or neurological injuries and pain (Kolvered, Joakim, Birgitta, Kessedotter, Gustafsson, 2012). Also, Fraczy and Godfrey, (2010), used a cross sectional survey among 275 patients on preoperative assessment of patients in the theatre and the results showed that some patients expressed general nervousness about a hideous death in theatre and pain after surgery. The participants indicated that they experienced a real challenge in theatre with regards to nursing management especially integrated pain management and anxiety.

A study at Sweden to assess patients' needs for a genuine caring encounter in the theatre using semi-structured interview involving a smaller sample size of nine patients, and some others studies, have stated that in terms of proximity, patients express the desire for Nurse Anaesthetists to be closed to them. The anaesthetist should handle them with trust, monitor and touch them during surgery to provide security and reduce the pain they are going through. This will make them have the feeling that not everything on them is monitored by devices (Ann-christin, Margaretha, Annika, & Sofia Almerud, 2013, Kolvered et al, 2011). Also some studies have shown that patients who are awake during surgery wish that the nurse anaesthetist communicate and interact with them during surgery. Besides they want to be received, listened to and respond to whatever need they convey to them during surgery (Ann-christin et al., 2013; Kaymackci, Yavuz, & Orgun, 2006). This study shows that it is important to be with the patients throughout the surgery. However this study used a smaller sample size and was

conducted in Sweden which a different cultural background hence, making it applicability difficult.

Studies conducted to assess specific pain management and outcome strategies during surgery using a semi-structured interview indicated that it is important to use multimodal analgesics and preventive analgesia that are aimed at reducing the sensitization during surgery. Other strategies that can be adopted to reduce pain during surgery are the use of minimally invasive procedures, adopting approaches to reduce stress responses and also optimizing fluid therapy (Girish, Stephan., & Henrik, 2014).

Ensuring that surgical patients' safety and prevention of infection is maintained is very important during surgery as expressed by surgical patients (Leape, & Berwick., 2009; Vaismoradi, Salsali., & Marck, 2011) . It is the nurses' responsibility to ensure the safety of the patients during surgery. Nurses need to be alert to dangers signs and conducting preventive interventions such as assisting patients to position well on operating table, walking and getting up from the operation table after operation and proper disposal of sharp objects (Butterwork, Jones, & Jordan, 2011; Kohlbrenner, Whitelaw, & Cannaday, 2011). Furthermore, it is stated that there is high risk of injury with the use of diathermy machine to both patients and staff which could lead to permanent disfigurement or death (Spruce & Braswell, 2012). Hence, before the operation starts nurses must ensure that the patients' body does not touch any earthed object such as the trim of the operating table or intravenous drip stand. Also the nurses should place a minimal material such as draw sheet or blanket between the patients' body and the return electrode mat. These activities would prevent any injury to patients (Rothrock & McEwan, 2011; AORN, 2009).

Also studies have shown that to prevent infection during surgery, nurses need to ensure that they comply with a number of good practices such as ensuring clean theatre

environment, applying aseptic techniques during surgery such as applying skin disinfectant, doubling gloving and elimination of sharp objects to reduce injuries to patients (AORN 2012a; Kelvered et al, 2011; Pratt et al., 2007). .

Studies have indicated that without proper coordination during intraoperation, critical information is easily lost and treatment delayed or misdirected. Also, it leads to a situation where contradictory information is given to patients to sort out alone (Toussaint, 2012). It stated that unclear information to patients about how a procedure is going to be performed or who is going to perform the activity creates worry and anxiety among patients (Birgitta et al, 2010). Hence providing adequate information to patients and using terms that patients can understand during operation is essential to ensure patient comfort which reduces worries during surgery (Degen et al, 2010). Also, patients who have had received information on what the surgery is about could develop a mental strategy and experience less unbearable pain during surgery (Nikolaj, Emil, Kazimierz, & Emilian, 2013).

2.5 Surgical patients' perspective on postoperative care.

The aim of postoperative monitoring and evaluation is to ensure that surgical patients return to normal activities as soon as possible. The main activities include fluid management, monitoring of vital signs, early mobilization including pain management (Janine & Teresa, 2010). Vital signs are often affected by surgery and anaesthesia and one of the functions of a nurse is surveillance which deals with monitoring of patients vital signs such as temperature, pulse, blood pressure, respiratory rate and oxygen saturation (Ahrens, 2008; Rogers, Dean, Hwang, & Scolt, 2008). These vital signs are monitored every 30 minutes for two hours and then hourly for two hours for the first 24 hours to detect any change in the patients condition that can be reported for correction to prevent complications (Zeitz & McCutcheon, 2006).

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In the United State of America, studies have indicated that poor nursing care causes many surgical patients to get complications such as phlebitis due to prolonged intravenous lines in situ (Royal College of Nursing, 2010). It is therefore recommended that intravenous line should be checked daily to ensure that it flows well and it should be removed when it has been in situ for more than 72 hours (RCN, 2010; Health Protection Scotland, 2012). Studies have shown that for surgical patients who have undergone non-gastrointestinal surgery, early oral hydration after recovery from anaesthesia was safe since it brings rapid return of patients to normal diet, early ambulation, early bowel movement and reduced thirst. It also decreases duration of intravenous fluid administration and shortened hospital stay (Al-Ghareeb, Ahmad, & Turki, 2013 Yin et al, 2014).

Weiran, Zhang, & Mu-Lian Woo, (2013), in a study of postoperative management in Chinese hospitals using quantitative method, reported that 82.8% of patients claimed that their post-operation pain was relieved within three days of their operation due to the analgesic drugs nurses administered. Hence some patients were thankful to the nursing staff for their good work. However, 51.6% of the patients mentioned that they received no treatment for their pain, 14.9% claiming medical personnel failed to manage their pain and 20.2% were unsatisfied with their pain management.

Also, Maier, Nestler, & Richter, (2010), investigating the quality of pain management using quantitative approach for 2255 postoperative patients in 25 German hospitals, reported that 29.5% of surgical patients had moderate to severe pain and 55% of them were not satisfied with their pain management due the failure of the nurses to respond to their to call when they were in pain. However, it has been indicated in a study that patients appreciate nurses showing confident and reassuring attitude toward them when they are in pain. This reduces their anxiety, promotes their physical activity and

reinforces their self-management strategies (Leonard, Tousignant-Laflamme, & Mercier, 2013)

Postoperatively, some patient mentioned that they received information when they were experiencing the lingering effect of the anaesthetic agent and consequently were drowsy and this influenced their ability to understand the postoperative information given to them (Blandford, Gupta, Montgomery, & Stocker, 2011). Those who could remember said they received contradictory information from the nurses making them more confused. Patients rather appreciated information from other sources such as physiotherapist, occupational and family members as most valuable information (Berg, Arestedt & Kjellgren, 2013). The study seems to suggest that nurses do not wait for the patient to fully recover from anesthesia before educating them. This often makes them confused and they do not appreciate the education given.

A qualitative study on wound dressing had shown that nurses remove their rings, watches, and also wear mask and gloves during wound dressing. Nurses also observe patients' wound more often when they are dressing the wound and report to patients the state of their wound. This makes them feel comfortable and happy (AORN, 2010; Reiko et al., 2013).

Early mobilization of surgical patients is very important for speedy recovery. Anna-Clara et al, (2010), in their qualitative study indicated that patients expressed difficulties and hardness to sit up, stand up and walk in and out of the ward after surgery due to postoperative pain. However, the patients described nursing staff as coaches as they turned them on bed, educated them on deep breathing and coughing exercise, regular gentle leg exercises to reduce complications such as chest infection, deep vein thrombosis and pulmonary embolism (Kibler et al., 2012; Masood, Zubia, & Abdullah, 2006). Other study also stated that patients praise nurses, saying that nurses assisted

them to bath, were quick to respond to their needs and help them to solve any problem that they encountered during their stay in the surgical ward (Beth Happ, et al, 2010).

Nurse- patient interaction and communication according to studies are the core component of nursing care in the ward (Stephanie & Zoe, 2015; Sieger, Fritz, & Them, 2012) with the main intention of this interaction and communication being to influence the patient health status or state of well being (Fleisher et al, 2009). Hence surgical patients believe that it is important for nurses to have open and honest discussions of the surgical goals with them (Kourkouta & Papathanasiou, 2014). Qualitative studies conducted also showed that patients were highly satisfied with nurses who came after the operation to check if they were feeling fine and were pleased with nurses who kept their promises and remembered to follow up their request (Mcmurray, Johnson, Patterson, & Griffiths, 2007). Contrary to this study, a descriptive cross-sectional study in Malaysia and some other studies indicated that some patients were least satisfied with the nursing care provided. The patients claimed nurses spent little time with them and were always in hurry and busy giving them the impression that they lacked time to talk to, listen or be with them (Inga et al, 2011, Teng & Norazliah, 2012).

A study conducted on 26 Jordanian patients' perspective of nursing care using qualitative design indicated that, nurses provided good nursing which included pain management interventions, health education regarding specific health concerns, timely answering of calls, safety and hygienic practices, discharge planning, follow-up and continuity of care (Al-Zaru et al, 2011). Some patients also said nurses continuously checked on them and asked if they needed anything. Nurses also establish and maintain a trusting, respectful relationship, protecting their privacy and integrity. They also involve them and their relatives in decisions regarding their plan of care, as well as

collaboration and coordination of care among the health care team (Al-Zaru et al, 2011; Khan, Anwar, Babar, & Babar, 2006).

Family support in nursing care during hospitalization is an indispensable fact in providing quality care. It has been reported in Ghana that, there are inadequate health personnel such as nurses to meet all the care needs of the patients. This therefore indicates that family members need to take part in the care of their patients (Ministry of Health, 2007). Also a study conducted to assess family preference for participation in care indicated that nurses are in a unique position to work with families as partners to provide quality care to hospitalized patients (Boltz, 2012). Also a qualitative study conducted in Malawi on family support and other studies stated patient are often accompanied by family members such as parents, spouses and children when they are hospitalized. These relatives are always at the bed side taking care of them by performing a variety of tasks on the ward. They bath their loved ones, collect medicine at the pharmacy or buy medicine in town for their relatives. They also make meals and feed their patients, serve medications and empty bedpan and urinal content (Osso, 2012; Hoffman et al., 2014; (Aziato & Adejumo, 2014b). It is therefore very important to encompass informed caregivers with the health care system and improve their training to perform medical care giving task (Levine, Halper, Peist, & Gould, 2010).

2.6 Discharge planning / home care

Educating patients on self-care upon discharge especially wound care and personal hygiene are very important to speedy recovery (Berg, Arestedt, & Kjellgren, 2013). Bodily care includes looking after oneself, eating well and exercising regularly through proper teaching. Ineffective teaching following discharge may lead to lack of knowledge about how to care for self at home and awareness of signs and symptoms of

any impending infections or complications (Pieper et al 2007; Tanner, Padley, & Davey, 2012).

A qualitative descriptive study conducted aimed at exploring ways of smoking cessation in post-discharged patients indicated that effective cessation counseling involves encouraging patients to modify their lifestyle through education (Chuan, Shoou-Yih Lee, & Yu-Qian Jeng, 2014).

Surgical patients wound care is the most important part of self-care. The patients need to change the dressing, assess the healing process and intervene if necessary. However, a study has shown that surgical discharge patients lack the required knowledge for wound monitoring due to poor discharge teaching, lack of self-efficacy for wound care at home and inaccessible communication with nurses about wound concerns resulting in wound infection (Sanger et al., 2013). Due to the failure of patients to get education from the nurses, more than 85% of them said they received help at home from family or friends' especially with wound care, household activities, and mobility (Foust, Vuckovic & Henriquez, 2012).

Also, in others studies, nurses failed to explain the purpose and side effect of the medications to some patients when they were discharged. Those patients who received information on medications said the information they received was not clear (Ann Schoofs et al, 2009; Diane, Mnistiae, & Kathryn, 2011). However, some patients had adequate discharge instructions on the list of medication, how to take the medicine at home, to take the medicine on time, to do exercise and to take good diet to improve recovery (Foust, Vuckovic, & Henriquez, 2012).

A study on nurses' performance on hospital discharge using a descriptive semi-structured method involving 65% females and 34% males with an average age of 48 in

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Sao Paulo State of Brazil involving 43 patients showed that 83% of the participants received tailored discharge instruction on medications, wound dressing and prevention of infection. However 72% of these patients received discharge instruction from other health personnel instead of nurses (Alcala et al, 2007). The study focused more on females than males even though the sample size was large. There should have been a balance in the sample size of the females and males to give a true picture of the findings.

Patients who were discharged home stated that the nurses only told them to go home with no assessment of what awaited them. No nurse even accompanied them out of the building or making sure their departure needs were met. In addition, there was no time a nurse assessed their learning needs, gave them advice on resources or enquired about their home situation with regards to their home care that could help limit their burden (Mcmurray et al., 2007; Mottram, 2011) These studies have shown that the nursing staff never planned for the patient discharged and this may compound patients post operative complications such as infection among others.

Studies have indicated that patients do have shorter number of days stay in the hospital do not get adequate communication from the nurses. Also, there is untimely, infrequent follow up; hence surgical site infection now occurs post-discharge. This puts much burden on patient at home who are not well prepared to manage it resulting in readmission (Kazaure, Roman, & , Sosa, 2012; Sanger et al, 2013; Saunders et al 2014). As a result, surgical patients believed that mobile health monitoring is highly acceptable. Nurses need to provide more frequent, thorough and convenient follow-up to assess their state of health at home upon discharge and this could reduce post-discharge anxiety and to help minimize the risk of adverse drug event after hospital (Mueller, Cunningham, Kripalani, & Schnipper, 2012; Sanger et al, 2013).

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Studies have indicated that, in perioperative care, patients' perspectives is important since many outcomes such as health related quality of life which includes the desire to regain health and satisfaction of care can only be reported by the patients (Grøndah, 2012; Pusic & Andrea, 2014). This confirms a quantitative study conducted in Kenyatta National Hospital involving 167 participants that indicate that, 52.4% of the participants are satisfied with their wound dressing (Shawa, 2012). Cost of hospital care according to studies, extend well beyond cost of medications, surgery and related treatment. Patients also incur indirect cost such as transportation and feeding (Kim, 2007). A prospective randomized pilot study conducted involving 1,061 patients undergoing ambulatory surgery showed that the elimination of routine does not affect perioperative adverse events but rather increases cost (Chung, Yuan, Yin, Vairavanathan, & Wong, 2009). Hence, to reduce this cost, studies indicate that, surgical assessment should be done on the surgery day, and urgent treatment should be given since a delay with these activities would increase patients' hospitalization and cost (Eko et al., 2013; Sehmbi, Wong, & Wong, 2015).

Qualitative studies that engaged patients during health care delivery indicate that, patients want improvement on certain surgical outcomes. These included pain management, post surgical exercise and wish that they should be incorporated into education during preoperative preparation. Besides basic training of nurses on communication skills, regular in-service training and workshops are recommended as ways that could improve on the quality of nursing care (Lane-Carlson & Kumar, 2012; Mensah, 2013). In addition, surgical patients prefer wound dressing materials that promote quick wound healing, reduce pain and ensure shortest hospitalization time (Corbett & Ennis, 2014).

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In summary, chapter two examined extensively literature on surgical patients' perspectives on preoperative, intraoperative and postoperative nursing care both at the hospital setting and postoperative home care. The literature covered the three research objectives which were developed taking into consideration the constructs of the PSH model used as an organizing framework of the study. The extensive review showed that there is inadequate exploration of perioperative experiences of patients in Ghana especially from the Northern sector of the country. This study will therefore fill the gap identified. The next chapter discusses the methodology used for the study.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the research design, the study setting, the sampling method and the nature of the sample, data collection procedure and analysis, rigour, and ethical considerations.

3.2 Research design

The researcher employed exploratory and descriptive qualitative approach for the study. Qualitative research design inquiry is often employed to describe a phenomenon by looking at the feelings, behavior, thoughts, insight and actions rather than number which is characteristic of quantitative methods. The researcher is able to describe the process relative to its context rather than outcomes (Mayan, 2009).

Qualitative method is appropriate for understanding individuals' and groups' subjective experiences of health and disease and interaction among participants and health care setting (Fossey, Harvey, McDermott, & Davidson, 2002). According to Polit & Hungler, (1999), the researcher obtains the information directly from the participants who are actually having the problems.

Also, qualitative research relies on the belief that humans are complex and have the ability to shape their own experiences from the perspectives of the participants and create meaning from it (Polit & Hungler, 1999). This approach was used to obtain information from the participants by capturing their perspective with regards to the perioperative nursing care they received. This approach was best for the study because it enabled the researcher to explore discharged general surgical patients' perspectives on perioperative nursing care they received while on the surgical ward.

3.3 Research setting

The study was conducted at the Regional Hospital, Bolgatanga which is located at the middle of the Upper East Region. The Upper East Regional capital is Bolgatanga. The region has a total land area of 729 square Kilometers and is bordered to the North by Bongo District, South and East by Taliensi-Nabdam District and Kassena-Nankana District to the West. The dominant tribe within the municipality is Frafra, however, there are almost every tribe in Ghana in Bolgatanga Municipality. Some of these tribes include Akan, Ewe, Dagomba and Ga. The dominant religions in the region are Christians and Muslims followed by the Traditionalists

The participants were identified and contacted at the Regional Hospital, Bolgatanga, which is located in the capital of the Upper East Region. The hospital is situated in the North-Eastern part of Bolgatanga in the suburb of Zaare. It was established on 13th January, 1953 to take care of an average of 300 in-patients and out-patients daily. It is about 0.50 kilometers from the Ghana Broadcasting Co-operation. The hospital is the largest hospital in the region and serves as a referral center to the other hospitals in the region. The hospital is bounded by Yikene to the West, Nyariga to the South, Bukere to the East and Tindonmolgo to the North. The hospital currently, has a total nursing population of about 160 nurses. Bolgatanga central hospital is a government hospital and it has twelve (12) Departments, which include: Surgical, Medical, Theatre, Maternity, Emergency, Psychiatric, Out Patient Department, Chest, Pediatric, Maternal and Child Health/Family Planning, physiotherapy and Ear, Nose and Throat Units. The surgical department in the Regional Hospital caters for about fifty (50) patients a day. The unit is attached to the theatre and located at the Northern part of the hospital.

3.4 Target Population

The target population for the study was postoperative patients who were discharged within the last one month and stayed within Bolgatanga Municipality. The study involved both males and females general surgical patients.

3.4.1 Inclusion criteria

Eligible participants included:

1. Patients who had general surgery at the surgical unit of the Regional Hospital, Bolgatanga and were admitted for at least 3 days.
2. Participants who have been discharged at least five days to one month and live within Bolgatanga.
3. Participants aged between 18 and above
4. Participants who can communicate in English or Grune language
5. Participants who gave informed consent and were willing to participate in the interview.

3.4.2 Exclusion Criteria

The exclusive criteria included:

1. Participants who were still in the ward and were receiving treatment.
2. Participants aged below 18
3. Participants who could not speak English or Grune language
4. Participants who were terminally/ seriously ill

3.5 Sample Size and Sampling Technique

The sampling size for the study depended on the data saturation when there was no new information. The data was saturated on the 15th participant. The participants were recruited using purposive sampling technique. Purposive sampling refers to situation where the researcher selects the participants based on the experiences the participants have. Besides the researcher selects the participants that can provide the needed information about the phenomenon under study (Patton, 2002). The researcher used this purposive sampling due to the fact that the researcher's target population was surgical patients who have had surgical experience and had received perioperative nursing care at the surgical ward. These participants were identified at the surgical wards when they were discharged. The participants were then contacted at their homes following the identification at the hospital.

3.6 Data Collection tool and Procedure

A semi-structured interview guide was used to conduct face-face interview to explore surgical patients' perspectives on perioperative nursing care. According to Khan, (2012), interview method is used to collect data from participants through face-face interaction and able to record the participants' responses which can later be cross checked for clarity. The semi-structured interview was appropriate for the study due to the fact that it allowed the participants to express themselves freely and also allowed the researcher to use probes during the interview to solicit for more divergent views that may arise (Kusi, 2012).

The formulation of the semi-structured interview was guided by the Perioperative Surgical Home (PSH) Model as a Microsystems Healthcare and the research objectives. Section A of the interview guide consist the demographic information about the

participants while section B consisted the interview guide (Appendix A) that made up of open-ended questions and probes.

The researcher booked an appointment with the participants after making an initial contact with the participants at the dressing unit or the outpatient department when they came for medical review. Later the researcher contacted the participants on phone or home visit to confirm the appointment date before he met the participants.

The interview was conducted using English or Grune language since the researcher understands and speaks the two languages fluently. The researcher maintained participants' anonymity by assigning them with pseudonyms. The researcher did an in-depth interview with each participant face-face and followed by probing questions to allow the participants express their feelings, thoughts and behavior about the nursing care they received on the surgical ward.

The researcher ensured that the participants felt comfortable. In a situation where a participant showed signs of tiredness or emotional distress the interview was stopped and continued later according to participant's desire. The interview allowed the researcher to clarify participants' responses to questions and probe on particular statements in more detail.

The researcher collected demographic data information which included age, type of surgery, and days on admission, sex, education, religion and occupation before audio taping the interviews. The interview was recorded and then later transcribed verbatim. The researcher also wrote field notes on all observations at the time of the interview. The interview lasted for 45 - 90 minutes.

3.7 Piloting the instruments

The interview guide was piloted at Builsa District Hospital, Sandema in the Upper East Region of Ghana. The Builsa District Hospital performs general operation just like the Regional Hospital at Bolgatanga Municipality. The Builsa District and Bolgatanga Municipality have similar geographical distribution and socio-economic conditions and similar cultural background. The participants that were chosen from the hospital were discharged patients. The interview guide was conducted on three participants to ensure that the questions were clear and lacked ambiguity. However the information gathered during the pilot interview was not part of the study data.

3.8 Data management

Data management refers to the storage and easy access or retrieval of data for easy analysis (Miles & Huberman, 1994). The researcher managed the data manually such that there was easy accessibility by the researcher and supervisors. Each participant was identified by pseudonym (FP1, or MP1, FP2 or, MP2 etc) where F represent female and M represent Male and the numbers of interviews were identified by figures such as 1, 2, 3 and so on.

The researcher transcribed all the interviews verbatim and created a margin at the right side to write the codes and themes. New files were created for each category and all information that was related to this category was kept in. Also the recorded tape, field notes and the transcribed data were added to the file and would be locked for five years after the study and after which it would be destroyed.

3.9. Data Analysis

Data was analysed concurrently with data collection using thematic content analysis technique to search for important themes and patterns in the data. Content analysis is the process of identifying, coding and categorizing the primary patterns in the data. It also involves organizing and integrating narrative qualitative information according to the emerging themes and concepts (Miles & Huberman, 1994; Polit & Hungler, 1999). It is a procedure for analyzing written or verbal communication in a systematic and objective manner (Punch, 2005). The interview was audiotape and transcribed verbatim by the researcher in English language. The data was organized into themes and sub-themes after transcription. The researcher read the transcribed data several times to make sure that the data conformed with what was audiotaped and had meaning out of it while taking note of the research questions of the study.

The researcher read the data and took note of repeated words, similar ideas and themes and coded them using the model applied in the study. The researcher further coded emerging themes or sub-themes through an interactive process. The identified codes were written in the margin besides transcript data. Recurring codes were grouped to form themes. Codes or themes that had similar meaning were grouped. When a theme occurred several times from several participants, a category was formed. Major categories were formed from related smaller categories as the analysis progressed. Also the researcher paid particular attention to the divergent views and minor responses raised by the participants in order to avoid over generalized conclusions (Miles & Huberman, 1994).

3.10 Methodological Rigour

In qualitative research, rigour is used to determine whether the information gathered from the participants actually represent the participants' experiences and can be trusted (Lincoln & Guba, 1985). Things such as credibility, transferability, dependability and confirmability are used to ensure trustworthiness in qualitative research (Polit & Hungler, 1999).

Credibility is used to assess the extent to which the research findings from the data accurately reflects the reality and is representative of the participants (Lincoln & Guba, 1985). The researcher applied prolonged engagement in the setting, member checking and triangulation of data to ensure credibility.

With the prolonged engagement, the researcher spent more time, at least two months on the field for collecting data. Apart from that, the researcher observed the participants gestures, mood and emotions and took note of them (Patton, 2002). The researcher interviewed both males and females who met the inclusion criteria and had different perspectives about the care they received from the nurses.

Also, peer debriefing and member checking are techniques used to ensure credibility of the research findings (Polit & Hungler, 1999). The researcher allowed regular peer debriefing through seminars where peers critiqued the research process and findings. It also ensured that all potential and inherent biases, beliefs and feelings from the researcher were identified and documented. Also by member checks, the researcher regularly validated the data from the participants to ensure that the data collected clearly represented their views. All the documents and data collected from the field were discussed with the supervisors to ensure correct interpretation of data generated. The researcher also transcribed and coded each interview conducted before the subsequent interview was conducted.

Transferability refers to the extent to which the research findings can be applied to other settings (Polit & Hungler, 1999; Lincoln & Guba, 1985). The researcher ensured this through detailed description of the research setting, methodology and the characteristics of the participants which included type of surgery, religion, marital status. These descriptions would enhance the applicability of the research findings to other similar settings, situations, context or population.

Dependability refers to consistency of the processes and the procedure used by the researcher during the research. To ensure consistency during data collection, it is therefore important to ask the participants the same question to ensure consistency (Polit & Hungler, 1999; Lincoln & Guba, 1985).

Also the researcher ensured dependability by using the same interview guide, tape-recorder, and methods used for analyses. Besides, the researcher discussed all the documents from the field with the supervisors and any feedback about the data was used to improve on the subsequent data collection.

Confirmability is ensured when the research findings reflect the participants' experiences and not that of the researcher experiences. The researcher ensured this by transcribing the information from the participants immediately to prevent misinterpretation in meaning. The researcher also developed an adequate audit trail which contained field notes, audiotapes, interview transcripts and documents on emerging themes and categories, notes from the member check, personal notes from the field and interpretation including draft from the final report. The audit enquiry would ensure confirmability of the data.

The researcher examined the beliefs, values and experiences of participants and did self-reflection on his beliefs, values and experiences in the same manner. The researchers'

beliefs and values were made clear and taken into account so as to help the researcher avoid biases (Hammersely & Atkinson, 1995). Also it involves cooperation with research team, data reduction and analysis and processing of notes. This would allow independent auditors to cross check the researcher's reasoning about the data.

3.11 Ethical Consideration

The researcher sought ethical clearance from Institutional Review Board (IRB) of Noguchi Memorial Institute for Medical Research, University of Ghana, Legon. The researcher later sought permission from the authorities of the Upper East Regional and Municipal Health Directorate and the hospital. This was done through introductory letter from the department of school of nursing, University of Ghana before the collection of data. The researcher approached the participants individually to explain the study to them. The participants were also provided with the information sheet and consent form. The participants were also told that their participation in the research was voluntary and that they could withdraw at anytime they wished to do so. The participants were assured that they would not face any harm when they took part in the study. The participant were informed that there would not be any direct benefits but their views would help them, me and others to know what they wanted from the nursing staff. This would also help the nurses to provide the necessary care patients want in the ward.

The participants that agreed to take part in the study were asked to sign a consent form. The researcher protected the participants' identity by using pseudonyms to ensure anonymity and confidentiality. Each participant's views were respected during the study. Any information from the participant had been locked in a cabinet and the key had been handled by the researcher. The next chapter looks at the presentation of findings.

CHAPTER FOUR

FINDINGS

4.1 Introduction

This chapter presents the results of data collected from the respondents on their perspectives of perioperative nursing care. The first part deals with the demographic data of the participants whilst the second part describes the various themes that were generated to answer the research questions taking into consideration the theoretical framework used to guide the study. Using thematic content analysis, three major themes and their corresponding subthemes emerged from the interviews. The major themes derived from the interviews were preoperative perspectives, intraoperative perspectives, and postoperative perspectives of care. The main themes and subthemes were presented by using pseudonyms with verbatim quotations from the participants. However, an additional theme that emerged as a result of content analysis was faith in God.

4.2 Demographic Characteristics

Fifteen participants comprising eight (8) females and seven (7) males who have had different types of operations were interviewed. Participants' age ranged between 23 and 65 years with three (3) in their early twenties, five (five) in their mid thirties, four (4) in their mid fifties, one in his early sixties and two in their mid-forties. Nine participants had some level of education ranging from middle school to tertiary education. These participants could speak English fluently aside the native language (Grunne). Six participants did not have any formal education and therefore could not speak English but spoke in Grunne. Four participants (three males (3) and one female), were not married but the remaining eleven participants were married. Five (5) participants had hernioraphy, (2) hydrocelectomy, two (2) amputation (leg), one (1) lipoma (abdomen), two (2) lumpectomy and three (3) appendectomy . Three of the participants had an emergency surgery whilst twelve participants had a planned surgery. Their religious

background included; five (5) Muslims, seven (7) Christians and three (3) traditionalists. The participants had varied occupations; seven (7) teachers, two (2) carpenters and one (1) business woman with the rest being farmers (7). All the participants were resident within Bolgatanga Municipality. Ten (10) of the participants were either given local or spinal anaesthesia and this allowed them to recount their operative experiences in the theatre (intra-operative).

In the quest to answer research question one; “What are the Surgical Patients’ Perspectives of Preoperative Nursing Care?” The study identified preoperative perspectives as the main theme consistent with the model with corresponding subthemes. This is presented with verbatim quotations of participants responses to support the findings.

4.3 Preoperative perspectives

Participants shared various perspectives on the preoperative nursing care. Participants’ perspectives were centered on nurses’ initial assessment such as patients’ assessment, patients’ consultation and prehabilitation and physical care. The sub-themes emerged included patients’ assessment and triage, patients’ consultation and prehabilitation and physical care. These sub-themes were also consistent with PSH model that guided the study.

4.3.1 Patients’ Assessment and Triage

Participants’ perspectives on assessment and triage were on various issues. These included; history taking, monitoring of vital signs and undergoing laboratory and radiological examinations.

Regarding history taking, a participant stated that a nurse asked her questions about her lifestyle and she thought one should be truthful in providing such information:

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“The nurse asked me questions about my lifestyle and I thought if they ask you questions you have to be truthful and do not tell lies. If they ask you whether you eat this or that and you tell lies it will not help you” (FP13).

Many participants reported that nurses did not ask them questions regarding their conditions. For example, a participant stated: *“No nurse asked me for any information about my condition or what I did before reporting to the hospital” (MP1)*. Some participants said that the nurses did not explain to them what their problems were but only said they needed an operation. A participant stated: *“...the nurses said I needed an operation but they did not tell me what was wrong with me” (MP7)*.

Other participants stated that it was the medical officers who asked them questions:

“...when I entered the room, the doctor asked me what was wrong with me and I said my stomach was always painful and a mass appears at the site any time the pain starts.” (MP5).

However, some participants could not give a good history on account of pain. A participant reported: *“The doctor asked me about my condition but my stomach was so painful that I could not talk much” (FP4)*. Another participant could not talk himself due to the severity of his illness, hence his relatives gave the history of his condition instead: *“I was awake but I was not having sound mind to know what was happening. The nurses called my brother to tell them what was wrong with me” (MP8)*. Again, it was reported that the nurses provided privacy in the consulting room. For example: *“The nurse provided privacy for me in the consulting room before the doctor examined me” (MP5)*.

With regards to vital signs, all the participants reported that nurses took their temperature, blood pressure and body weight preoperatively. For example, one of the participants explained that before the surgery:

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“They (nurses) checked my body. They put one glass thing under my armpit and wrapped the other around my arm and pumped it” (FP4).

Other participants stated that the nurses used a machine to check their body weight in addition to temperature and blood pressure: *“They (nurses) told me to stand on a machine and she would record my body weight” (MP2).*

However, participants had various perspectives about the way the nurses took their temperature, blood pressure and weight. Some felt happy that the nurses explained to them what they were going to do and that there would not be pains. A participant thus explained: *“Before the nurse took my temperature and blood pressure she told me that she was going to put the thing at my armpit and that it will not be painful and I agreed for her to do it” (MP1).* Others also mentioned that the nurses smiled and thanked them during and after the procedure: *“He held my hand, smiled to me and I also smiled to him and after the procedure he thanked me” (FP4).* However, one participant echoed that he felt some discomfort when the nurse took his blood pressure: *“I felt some pains and dizziness when the nurse wrapped the thing around my hand very tightly and pumped it” (MP2).*

Some participants stated that the nurses did not explain these procedures before starting them. One participant said:

“The nurses told me to sit on the chair and I sat down and they checked my temperature and blood pressure but they did not tell me what they were going to do” (MP1).

Also, the participants stated that the nurses did not tell them the significance of values they recorded. A participant stated: *“The nurse did not tell me the importance of taking my body temperature and blood pressure or what values she had when she checked” (MP7).*

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However, some participants thought that it was beneficial when nurses took their vital signs. For example, a participant stated that when the nurses took her blood pressure they told her that her blood pressure was high and it needed to be stable before they could do the operation. *"...when the nurse took my blood pressure she told me that my blood pressure was high and they need to reduce my blood pressure before they could do the operation."*(FP10).

All the participants went through one investigation or the other preoperatively. Participants were asked to do some laboratory investigations such as hemoglobin level, blood grouping and cross matching. For example, a participant said she was asked to go to the laboratory and do some tests:

"I went to the laboratory after I was admitted on the ward and I did some test which I can still remember were blood grouping, hemoglobin level, HIV status and hepatitis B and C " (FP15)

Other participants however, did not know the type of test they were asked to do. A participant stated *"The nurse told me to go and do blood test but I did not know the type of test I was going to do"* (MP2). Some participants said they were not told the results of the blood test: *"The nurse told me to go to the laboratory and do some blood test but he did not tell me the results of the test when I did it"* (MP5).

" One nurse brought the results later when I was on bed and told me that is the results and kept it in the folder but she did not tell me the results and I also did not ask her" (MP2).

Also, participants reported that the laboratory technicians did not explain any procedure to them before they took the blood sample: *"The laboratory man did not tell me what he was going to do. The man only asked me to come in and I went in and he took my blood"* (FP12). All the participants also emphasized that they did not get the laboratory results immediately but had to go to the ward and wait for it. A participant stated: *"The*

man took my blood and told me to go back to the ward and that when he finishes he would bring the results to the ward” (MP1).

However, one participant said that after she had done the test, she was told about the abnormal results and the intervention needed:

“After the laboratory test the nurse told me that I do not have enough blood so they will give me two units of blood before the operation will be done” (FP10)

One participant had abdominal ultrasounds requested:

“I had an abdominal problem and the doctor told me to go for a scan and I went and took the picture and he told me that I need to do operation” (FP14).

FP4 also said:

“I was having stomach pains and they gave drugs and I took the drugs but it was still painful so the doctor said I should go and take a scan. When I took the scan, he told me I had appendicitis and needed an operation” (FP4).

Some participants were rushed to theatre for emergency surgery following assessment.

A participant reported: *“I was at emergency room when the nurses came and sent me straight to theatre for the operation” (MP3).* Another participant added:

“The nurse gave me infusion at the emergency ward and passed a rubber like tubes, one to my private part and the other to my nose before they sent me to theatre straight without going to the ward” (MP4).

4.3.2 Patients' consultation and pre-habilitation

Participants' perspectives on patients' consultation and pre-habilitation were focused on the various pieces of information and education they received from the nursing staff.

Others included counseling, pre-habilitation training, reassurance and administration of infusion and pre-medication preoperatively.

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Some participants received information on the items they should buy. For example, a participant said: *“The nurses told me to buy blade and they will come and shave my pubic hair for the following day’s operation”* (MP1). Some received information on the need to collect drugs at the dispensary. *“The nurse told me to go to the drug store (dispensary) and collect drugs so I told my brother and he went to the drug store and collected the drugs”* (MP9). Some participants were told to go to the laboratory for blood test: *“The nurse told me to go to the laboratory and do some test”* (MP5). Other participants said nurses told them that they should not eat in the evening *“...but later in the evening another nurse came and told me that I should not eat that night because the following day, they will do the operation”* (MP9). Some participants were shown the bath room, toilet and urinal: *“After the nurses gave us a bed, the nurse came back and asked the two of us who were on the ward to follow him and he showed us the bathing room, urinal and toilet”* (MP7). Some participants reported that nurses told them to bath with soap and water after shaving: *“The nurse told me to bath with soap and water after shaving and I did that before the operation”* (MP1).

However, one participant stated that although the nurses told her what to do, because they did not monitor her she did not follow the instructions: *“The nurses told me to bath but I was feeling lazy to bath and they did not monitor me so I just relaxed on bed and did not bath the day of the operation”* (FP15)

Also, some participants were told to remove all the items they were wearing and wear the gowns given to them. A participant reported:

“The nurses told me to remove all the things I was wearing such as earrings, beads, brassier, pant and wore the gown before I could enter the theatre and I did just that”(FP12).

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Another participant said he was told to remove his rings: *"I was wearing a ring and one nurse told me to remove it before I enter the theatre"* (MP3).

Again, nurses educated some participants on the essence of their operation. A participant stated: *"The nurse told me that the operation may stop my stomach pains and if I do not do the operation one day I cannot even get up"* (MP1).

Some participants mentioned that nurses explained to them the procedures they were going to carry on them and sought for their cooperation:

"The nurses explained to me that they are going to insert the rubber through my nose into my stomach in order to remove the dirty content" (FP4).

Another participant added:

"The nurses begged me to cooperate with them to insert a rubber like tube into my penis to allow the urine to flow out when they operate me" (MP3).

Also, some participants stated that nurses counseled them to stop certain life style practices before surgery: *"The nurse also told me that I should stop smoking or drinking before they do the operation even though I do not drink or smoke"* (MP9).

Others were counseled on exercise to do postoperatively: *"The nurses also told me that after the operation I should not lie down but I should always walk little by little on the ward"* (MP1).

Another participant added:

"The nurses told me to be exercising my arm and I should always try to move the arm up a little and not too much because anything can happen" (FP15).

Some participants received pre-habilitation training on how to use crutches and walk. Participants who had amputations were encouraged to use them after the operation:

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“The nurses told me that after the operation I would be using crutches to walk so when the man brought the crutches, he taught me how to use them and told me that after the operation I should be using them so that I could be used to walking with them”(FP10).

Some participants reported that nurses reassured them to relieve preoperative anxiety. They said nurses reassured them through various ways which, to some participants, helped to reduce their fear and panic. A participant stated that he was afraid but the nurses told him to relax and not be afraid because of competent care:

“The nurses told me that I should relax and should not entertain any fears, the doctors are good and everything will be fine for me” (MP2).

A participant stated that she was told about the theatre and how the personnel dressed and that made her happy:

“The nurse told me there is a big light in the theatre and they will be wearing caps and will cover their nose so I should not be worried if I see that and that gave me fair idea about what would happens in the theatre and I saw exactly that so I was happy”(FP15)

Another participant emphasized that he was confused and panicking because that was his first experience of surgery but the nurses reassured him:

“When I entered the theatre, in fact I must tell the truth I have never had an operation so I was afraid but the nurse told me that I should not be afraid; nothing bad will happen to me” (MP5).

Others also felt they had the courage to go in for the operation because they had seen other patients who went through the operation successfully. A participant reported:

“My heart was beating but when I saw my colleague whom they had operated upon walked to the ward, then it made me feel that the operation was simple”(MP7).

But MP3 felt he was neglected and did not get reassurance from nurses: *"I was confused and panicking when the nurses brought me from the emergency ward to the male ward; they left me alone on the stretcher without reassurance"* (MP3).

Some participants had analgesics and intravenous infusion preoperatively during consultation. A participant stated that: *"The nurse came and gave me the injection and within 30 minutes my pains stopped and I was relaxed on bed"* (MP1). A participant emphasized that she thought she would feel pains when she was injected but that was not so:

"I thought when the nurse injects me and I will feel pains but she injected me quietly and I did not feel any pains, God should help the nurses with their work" (FP13).

Some participants were given intravenous infusions and some reported that this was done because of the emergency nature of their conditions: *"They only set the intravenous line on my hand because my case was an emergency"* (FP4).

However, others reported that the nurses gave them infusion preoperatively as a routine care. *"They (nurses) also put intravenous line on my hand to give me water"* (FP10). Another participant said that the nurses cleaned the site before setting the line: *"The nurse sought permission from me and then cleaned my hand with cotton and water before she set the line"* (FP14).

4.3.3 Physical Care

The participants reported that nurses provided them with physical care to them preoperatively. Some of the activities performed included; shaving of hair, bathing, and wearing participants' gowns, passing nasogastric tube and urinary catheter. Although these have been mentioned briefly under patient consultation and prehabilitation, further dimensions of these findings are presented.

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Participants had various perspectives on their personal hygiene before surgery. Some participants stated that nurses provided privacy, shaved them and cleaned the surgical site before the surgery: *"I bought the blade and the nurse brought something and screened my bed and then shaved me well. Oh I was so happy and thanked the nurse for the work done (MP1).*

Another participant added: *"They (nurses) brought something to screen my bed and clean the area with soap and water"* (FP6).

However, some participants reported that the nurses ensured that they had shaved themselves properly: *"The nurse ensured that I shaved myself well and washed the area with soap and water before I entered theatre"* (FP15).

Some participants stated that they shaved at home before coming to the ward but the nurses inspected them and shaved again

"I told the nurse that I had shaved at home before I came but he looked at it and said it is not well done so my brother bought a blade and he shaved me again and washed the site with soap and water " (MP9).

However, one participant said that when she told the nurse that she had shaved before she came to the ward the nurse inspected it and was satisfied with it:

"When the nurse asked me whether I have shaved and I said yes I shaved before coming to the hospital. The nurse looked at the shaving and said it was well done" (FP12).

Other participants also stated that they did not bath before the operation because they had bathed at home and the nurses did not ensure that they bathed. *"I bathed at home before coming to the hospital so I did not bath again before the operation. The nurses did not ensure that I bath"* (MP7).

Some participants reported that the nurses passed both urinary catheter and nasogastric tube preoperatively. *“The nurses put rubber (catheter) into my urethra and passed another tube (Nasogastrict tube) through my nose into my stomach before they sent me to theatre”* (FP4). Another participant also stated: *“I was not feeling well but I could see that the nurses passed a rubber like substance (catheter) into my private part and also pass another tube into my nose”* (FP11).

Participants also said nurses explained the importance of passing the urinary catheter and the nasogastric tube to them before the procedure:

“The nurse told me that the dirty things in my stomach and the urine would pass through the tube (nasogastric tube) in my stomach and the tube (urinary catheter) in my penis and come out” (FP4).

In answering research question two; “What are the Surgical Patients’ Perspectives of Intraoperative Nursing Care?” The study identified one main theme which was intraoperative perspective. The theme has been presented with some subthemes and verbatim quotations of participants’ responses to support the findings.

4.4 Intraoperative perspectives

Participants had various perspectives about the care they received during the intraoperative period. They reported that nurses provided care such as intraoperative information, monitoring of vital signs and fluid and integrated pain management. They also ensured participants’ safety and prevention of infection during surgery. Subthemes included; intraoperative information, monitoring of vital signs and intravenous fluid, integrated pain management, safety and infection prevention.

4.4.1 Intraoperative information.

Participants received various pieces of information from the nurses when they were lying on the operation table. Some participants mentioned that nurses informed them

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that they would plug a machine on their legs during surgery and that if they felt some pain they should tell them: *“When I laid on the operation table, one of the nurses told me that they would use something to put on my leg (diathermy) and that if I feel some pain I should tell them”* (FP14). Other participants for hydrocelectomy stated that: *“Before they started the operation the nurses told me that I would be feeling some warmth under my scrotum, I should not be worried because it was a machine they were using”* (MP7). However, others were not informed about the use of diathermy before the surgery: *“They did not tell me that they would plug a machine on my leg before the surgery”* (MP1). Another participant also added that when they started the operation he thought they used a scissor to cut something but he realized later that they were using a machine to cut him: *“I thought that it was a scissor they used to cut me but later, I realized it was a machine he was using to cut me”* (MP3). Some participants were also informed that the nurse would give them injection and they would experience little pain when they lay on the operating table: *“They gave me injection and told me that I will experience mild pain and truly I did”* (FP15). Participants were also reassured:

“The nurse told me to relax and that they would soon finish the operation. So within few hours the doctor finished the operation and the nurse told me they had finished so I should get up” (MP2).

However, a participant stated that she became afraid when there were consultations among the doctors as to who should perform the operation:

“I became more afraid because one of the doctors asked the colleague doctor that was going to operate me whether he had ever operated on the breast before and he said no; it is like he operated on only one person. The doctor then said he should leave and he would do it for him to observe” (FP12).

4.4.2 Monitoring of intraoperative vital signs and intravenous fluid.

Some participants stated that the nurses monitored their vital signs and intravenous fluids during the operation. A participant reported: *“When I reached theatre, they (nurses) took my body temperature and Blood pressure”* (FP4). A participant emphasized that the anaesthetist in the theatre was monitoring her vital signs: *“As for the theatre, especially the operation room the nurse was using a machine to pump my hand and the alarm was just going on like that”*(FP11). Some participants reported that they observed what was going on around them: *“I was awake and could see water hanging and flowing into my body”* (FP10). Another participant stated: *“The nurses hanged the intravenous fluid when I was lying down on the operation table”* (FP15).

4.4.3 Integrated pain management

Participants had varied perspectives about the management of their pain during surgery. Some participants' experienced mild pain during surgery because of the injection they were given: *“A nurse injected me before the operation and that made me to feel mild pains during the operation”*. (MP2). Other participants said they felt pain during the operation and they complained and the nurses apologized to them and added more analgesics: *“I felt pains so I screamed and they said sorry and I heard them saying they should add more injection and the nurse added the injection and the pain was better”* (FP12).

Some also felt that their pain reduced when the nurses touched and spoke to them during the operation:

“I was crying because of the pain and the nurse held my head and told me to be patient and take it easy since they were about finishing and when he was doing that to me I was not feeling any pain”(MP3).

However, a participant stated that he told the nurses to remove the machine plugged to his leg since it was burning his leg but the nurses did not remove it: *"I told them to remove the machine attached to my leg because it was burning my leg, but they did not remove it. Look at the sores on my left leg that is the machine (participant showed a healed sore on the leg)"* (MP1).

4.4.4 Safety

Participants' perspectives on safety during surgery indicated that they received various forms of assistance from nurses that ensured their safety. Some participants indicated that they were assisted by the nurse to lie on the operation table: *"When I entered the room the nurses assisted me to lie on the operation table"* (FP4). Others had to be lifted: *"I was lifted from a stretcher to the operation table and when they finished they lifted me onto the stretcher again and called the nurses to come and send me to the ward"* (FP10). Some participants said that the nurses positioned them well on the table such that they could not fall off: *"They protected me from falling by placing my hands the arm rest attached to the table and my legs were lying straight on the table and I could not move my hands"* (MP5). Others, who had minor surgeries such as inguinal hernia, said that the nurses assisted them to get up from the operation table and also assisted them to walk to the ward: *"The nurse held my hand and told me to step on something and get down from the operation table. He then called the nurses to assist me walk to the bed"* (MP7).

4.4.5 Infection Prevention

Participants reported various perspectives about infection during surgery. All the participants mentioned that nurses used some solution to clean the site to be operated: *"I know it was medicine they used to clean my abdomen before they started the operation"*

(FP6). Another participant echoed: *“I believe it was medicine they used to clean my scrotum before they started the operation”* (MP7).

All the participants stated that they were draped before the operation. A participant emphasized: *“The nurses folded the green cloth I was wearing up to my chest level and used a cloth to cover the site they were to do the operation”* (MP9). Another participant added that: *“They used a green cloth and covered my stomach after cleaning”* (FP10).

In a quest to answer research question three “What are the Surgical Patients’ Perspectives of Postoperative Nursing Care including Discharge Planning”; the main theme identified was postoperative perspectives. This is presented with verbatim quotations of participants’ responses to support the findings.

4.5 Postoperative Perspectives

The participants shared various perspectives on postoperative nursing care. Their perspectives were based on how nurses cared for them on areas such as postoperative monitoring and evaluation, how they ensure participants meet their daily needs and how nurses planned with participants toward discharge home. Also, their perspectives on the perceived quality of care in terms of clinical outcome and cost were gathered. Besides, suggestions on improvement areas were also gathered. The subthemes that emerged and were consistent with the model included monitoring and evaluation, activities of daily living, discharge planning and perceived quality of care.

4.5.1 Monitoring and Evaluation

Participants shared various perspectives on the monitoring and evaluation of their conditions after their operations. Participants’ perspectives were based on nursing care activities such as vital signs, fluid management, pain management, drug effect and wound care.

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Participants had varied perspectives on the monitoring of their temperature and blood pressure on the ward after surgery. Some participants stated that immediately they were brought to the ward from the theatre the nurses took their temperature and blood pressure: *“One nurse came immediately and took my blood pressure and temperature and wrote it in the folder”* (MP5). Other participants had their vital signs measured a while after the operation: *“I lay down for about one hour before two nurses brought their things and took my temperature and blood pressure and went away”* (MP2). Others were given injection after the nurses had taken their temperature and blood pressure: *“The nurses took my body temperature and blood pressure and gave me injection”* (MP3). A participant emphasized that the nurse took her blood pressure and said it was high: *“The nurses said my blood pressure was high and I told her that I was scared in the theatre”* (FP15).

Another participant said that the nurses always checked his temperature and intervened to correct abnormalities:

“The nurses always took my temperature and said it was high, so they would let me buy some medicine for them to insert into my anus and within some two minutes my body will be cold”(MP3).

Some participants reported that nurses monitored their intravenous fluid when they were on the ward. A participant stated: *“The nurses were always giving me water and they would come to look at the infusion to see whether if it had finished and they would give another infusion”* (FP4). Another participant stated: *“When the water finishes the nurses changed the water and hanged it for me”* (FP14). However, participants who had intravenous drugs in the form of infusions such as Metronidazole, reported that, the nurses would always wait for the infusion to finish before they left their besides: *“The nurses would always be with me till the small infusion finished and they would hang the bigger water before they left”* (FP4). However, all the participants reported that the

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nurses did not encourage them to take oral fluids early after the operation: *"No nurse encouraged me to take water when I was lying on the ward after the operation"* (MP3). Another participant added: *"The nurses did not tell me to take water even though I walked to the ward myself and was thirsty"* (FP1).

Participants were given drugs to reduce postoperative pain. A participant stated: *"After one hour I was feeling pains and I told the nurses and one of them gave me the medicine that I collected from the dispensary and the pain reduced"* (MP2). Some participants stated that the nurses gave them medicine two hours after their operation: *"The medicine that I collected at the dispensary the nurses gave me some to take after two hours of the operation"* (MP5). Some participants did not know the names of the drugs they were given to reduce the pain: *"I do not know the names of the drugs, but the nurses were giving me the drugs anytime I was in pains"* (FP11). However, a participant who was graduate teacher knew the analgesics she was given: *"I was given diclofenac injection when I was in the ward and then tablets Ibrufen 400 mg when they were about to discharge me from the ward"* (FP15). A participant experienced severe pain at night but did not take any analgesic till the next morning even though he was suffering: *"I thought I was dying because the pain was too much so I was lying there without control of myself till day break without taking any medicine"* (MP3).

A participant stated that the nurses advised him on how to get up from bed without damaging the sutures or feeling any pains:

"The nurse told me that if I lie down and want to get up I should turn on my side and get up well but if I lie down on my back and I want to get up the sutures can remove and I will also feel more pains" (MP5).

However some participants said they were not given such information: *"They did not teach me how to position myself so that I would not feel pain or experience less pain"*

(FP14). Some participants experienced pain the following day but the nurses' reassured them.

"After the operation, the following day, my body was warm and I had some pains so I complained to the nurses and they said it is because of the operation, I should not worry the pain would go"(FP4).

However, some participants were not reassured when they were in pain: *"The nurses did not reassure me when I complained of pain"* (MP2).

Participants recounted various perspectives about the effects of the drugs they took throughout their stay on the ward. A participant reported: *"When they finished the operation I was dizzy and the nurses assisted me by holding my hands to lie on the bed"* (MP2). Another participant added: *"I was dizzy and the nurse was saying something that I did not understand"* (FP6). One participant also reported that because of the drug effect, she had secretions from her mouth which was cleaned:

"I heard the nurse saying that if the saliva is coming out I should try and bring them out and I should not worry. So when the saliva was coming out the nurses used cotton to clean my mouth" (FP4).

Some participants stated that their wounds were well taken care of and healed fully: *"The nurses dressed my wound nicely and on the third day the nurses told me that my wound is almost healed"* (MP2). Other participants' wounds became infected and the nurses told them to buy hydrogen peroxide to be used for the dressing:

"The nurses told me to buy medicine (hydrogen peroxide) to dress my wound because my wound was infected and I bought it and they have been using that to dress my wound" (MP1).

Some participants emphasized that the nurses provided privacy whenever they were dressing their wounds: *"The nurses normally come themselves and screen my bed and dress my wound"* (FP4). Some participants did not receive any information on the state

of their wound after dressing. *"The nurses did not tell me the state of my wound after dressing. They only dressed the wound and said tomorrow they will dress it again"* (MP9).

4.5.2 Activities of daily living

Participants' perspectives on meeting activities of daily living revealed components such as personal hygiene, mobilization and interaction in the ward. Some participants reported that nurses helped them maintain good personal hygiene: *"The nurse cleaned my body on the first day I came out from the theatre"* (FP4). Others said: *"The nurses changed my bed sheet whenever my bed sheet was dirty"* (FP11). Another participant echoed: *"The nurses changed a bed sheet for me when my sister went to wash my bed sheet"* (FP14).

Some participants felt that their relatives provided them with the care they needed. A participant stated: *"My daughter in law was cleaning my body everyday in the morning and in the evening with soap and water when I was on the ward"* (FP11). Another participant added: *My wife always bathed me when I was on the ward"* (MP3). Another participant said: *"Even if my bed sheet becomes dirty my sister would wash it for me"* (FP14). Some participants also mentioned that their relatives discarded their urine when they were on the ward: *"The nurses kept a urinal by my bed side and if I urinate, my wife will pick the urine to the toilet and empty it"* (MP7). Another participant added: *"When I felt like urinating I tell my daughter to give me the bowl and I would bend down slowly and urinate and she would pick it and empty it at the toilet"* (FM13). For others, their relatives went to the dispensary for their drugs: *"My daughter was always going to the dispensary to collect the drugs and we do not buy"* (MP5).

Some participants stated that they were encouraged to do early mobilisation to enhance their speedy recovery. A participant reported: *"The nurses always came and told me*

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that I should always get up and walk around. The nurses said it would help me to go home early and the wound would heal on time” (MP1). Others also got assistance from the nurses to sit up on bed: “...So the nurses always helped me to sit up on bed” (FP4). Others had self motivation to do some exercises on the ward: “I was always having the urge to walk on the ward especially in the morning and in the evening so I was active” (MP9).

4.5.3 Discharge planning

Participants' perspectives on discharge planning centered on the education participants received from nurses before they were discharged to help them care for themselves at home. Participants received education on areas such as self care practices at home, nutrition, medication, wound care and follow up. Participants' perspectives on self care were education on lifestyle counseling and hygienic practices that were beneficial to their health at home.

All the participants reported that nurses told them that they should not smoke or drink 'pito', a locally brewed beer as that would affect the healing of the wound. A participant emphasized: *“The nurses told me that I should not drink pito or smoke cigarette” (MP1). Another participant added:*

“The nurses told me that I should not drink otherwise I would get drunk and fall and probably hit the sore on the ground or sit on the scrotum. I should avoid taking cola nut since it can cause irritation that can make me cough and caused pains” (MP7).

Also FP4 reported that the nurses told her that she should not lift heavy objects or do any heavy work that could lead to postoperative complication: *“I should not lift any heavy object and I should not do difficult work that can cause me problem” (FP4).*

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All the participants reported that they received information from nurses on things that they should do to prevent wound infection. A participant stated: *“The nurses told me that I should not let water get to the wound site to promote infection”* (MP3). Another participant said: *“My wife always cleaned my body with sponge, soap and water because the nurses told me that the wound should not be wet”* (MP5). However, some participants said they were not told to keep the wound dry: *“The nurses did not tell me that I should keep my wound dry”* (FM14).

Some participants reported that nurses educated them on the kind of food they should eat when they were discharged: *“The nurses told me I should be eating fruits, vegetables, oranges, fish, meat and others”*(MP3). Another participant echoed: *“The nurses advised me that I should not eat hard food but I should be taking light soup, porridge”* (FP6).

However, some participants stated that the nurses did not educate them on what food to eat but told them to come for their wound dressing.

“No nurse discussed anything about nutrition to me, like I should eat this food or that food. It is only the dressing day they told to come back for the dressing of my wound” (MP5).

The participants were told how to take their drugs at home: *“One nurses showed me that I should take one tablet in the morning, afternoon and in evening. She also told my sister to always remind me to take the medicine at home”* (FP4).

Another participant added:

“The nurses showed me how I should take the drugs at home. They told me that I should take the drugs in the morning, afternoon and evening” (FP13).

Others were told to take the drugs regularly but not given specific details: *“The nurses said I should be taking the drugs regularly but they did not tell me the time I should*

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take the drug" (FP12). Some participants also followed the inscriptions on the sachet to take their drugs at home. *"The drugs that they gave me from the hospital, it has been indicated on the sachet how it should be taken so I have been following that inscription to take my drugs"* (FP15). However, all the participants said the nurses did not educate them on the side effect of their drugs: *"No nurse told me about the side effects of the medications that I was taking"* (MP5). *"The nurses did not educate me on the side effects of the drugs I was taking at home"* (FP13).

All participants reported that the nurses told them to come to the ward for the daily dressing of their wounds. Participants were given different dates to come for the dressing. A participant stated: *"The nurses told me to come to the ward every three days for the dressing"* (MP3). Another participant added: *"The nurse told me to come to the hospital every two days for the dressing"* (MP1). Another participant added that nurses advised him on how to keep the wound clean: *"...I should not expose the wound to dirty things like my dress and I should wash them well"* (MP1).

Some participants reported that some of the nurses would dress their wounds and express the pus whilst others did not do so: *"Some nurses would dress the wound and pressed it for all the pus to come out. But other nurses would dress the wound without pressing and you would not even feel any pain"* (MP5).

All the participants said that some nurses did not wear mask when they were dressing their wounds: *"Some of the nurses did not wear anything to cover their mouth and nose when they were dressing my wound"* (FP10).

However, all the participants reported that the nurses did not educate them on the signs of wound infection: *"The nurses did not teach me the signs of wound infection"* (FM10). *"The nurses did not tell me any danger signs of wound infection"* (MP8).

The participants reported that no nurse visited them at home or even called them on phone to find out how they were doing at home. A participant stated that the nurses informed her to come for review but if there was a problem, she should report to the hospital immediately:

“The nurses said I should know the day that they told me to come for review but if there is a problem I should come and should not wait for that day. They did not visit me at home” (MP9).

“The nurse told me that I should come back today for him to see how I was doing at home.” (FP14).

Another participant added: *“I wish nurses had visited me at home to see how I was doing. I believed my wound got infected at home” (MP3).*

4.5.4 Perceived Quality of Care

Participants' perception of the quality of care was concerned with nurses' communication, the cost of care and clinical outcome of their surgeries. Some participants mentioned that nurses communicated with them well during procedures:

“The nurse told me “oh mama, please; I want to give you injection and even said sorry before injecting me” (FP10). Another participant added that some nurses were good and polite;

“In fact some of the nurses were good. When they came in the morning they would greet me nicely and chat with me. Some were also showing respect to me by speaking politely to me and some would ask me whether I had any problem that I want to share with them” (MP3).

However, some felt that nurses did not communicate well with them. A participant emphasized: *“My wound gaped and I was rushed to the ward and the nurses were*

shouting at me saying that I was careless” (FP4). Another participant said that a nurse spoke rudely to him:

“One nurse spoke rudely to me at the dressing room. She said you cannot put medicine down and it poured. I could not talk and my tears were flowing from my eyes.” (MP8).

Some participants pleaded that nurses should talk nicely to participants to allay their anxiety and fear before the surgery:

“It is good that nurses should talk nicely to patients about the operation especially those who have never had an operation so that their anxiety and fear will be better” (FP14).

Participants gave varied perspectives on the clinical outcome of their conditions.

“As for the dressing, the nurses in the room were doing well. In fact they dressed my wound very well. Look at the wound it is almost healed after two weeks of operation” (MP1).

MP7 emphasized: *“I am so happy that I have finally done the operation. At first I could not work effectively because of my swollen scrotum but now I do the basic work without any problem”*

Some participants also praised nurses for the good work done.

“If I say the nurses did not handle me well then I would be telling lies. In fact God would bless them all. The nurses should try and extend this kind of care to anyone that comes to the hospital” (FP10).

However, some participants felt otherwise.

“The nurses refused to dress my wound saying that I came late even though I was feeling pain at the site of the wound. They only added a plaster to hold the old dressing in place” (MP3).

“Hmm, if they could train nurses to dress the wound nicely it would help to reduce infection. The doctors would do the operation nicely and everything would be fine but because they do not dress the wounds well, the wounds are always infected” (MP5).

Participants had varied perspectives about the cost of their hospital care. A participant, who was not a registered National Health Insurance Scheme member, said: *“My husband’s brother was giving me the money to buy the drugs otherwise I could not have afforded the cost” (FP14).*

All the participants who were to do some laboratory and radiological examinations, paid for the cost. *“I was asked to take a scan two weeks before the operation but because of the cost involved; it delayed my surgery even though I had health insurance” (MP1).*

“Because I did not have insurance, I really had a lot of problems especially with the buying of the drugs and the settlement of the hospital bills so I stayed longer on the ward even though I was discharged” (MP8).

Some participants also presented late to hospital on account of lack of funds.

“In fact my testis was enlarged for a long time but I was not having money or health insurance card to come to the hospital for treatment. So I gathered enough money and came to the hospital for the surgery (MP7).

4.6 Faith in God.

This was a coping strategy employed by the participants to enable them go through the surgery. Faith in God was an additional theme that emerged from the study.

Some participants believed and had faith in God and therefore they ‘prayed’ to God to take them through successful surgery. *“I prayed to God by reciting the rosary because I believed and had faith in Holy Mary to guide me through the operation and after the operation” (FP15).*

FP10 added:

“ I knew of people who came for operation and did not come out alive and I have seen people who came out from theatre and died on the ward so I gave my life to God because I believe and have faith in God”(FP10).

Some participants praised God for seeing them through the operation successfully. A participant stated. *“I really thank the almighty God for taking me through the operation”* (FP11). Another participant added: *“I gave praises and glory to God. It is God who gave nurses and doctors patience, good heart and hands to work on me and I was ok”* (FP13).

4.7 Summary of the findings

The study identified that nurses took some participants' medical history, monitored their vital signs, weight, and also ensured that their laboratory and radiological investigations were carried out during patients' preoperative assessment. Also preoperative medication and intravenous fluid were administered to some participants as prescribed. Participants were also identified as emergencies during assessment and were given urgent attention. Nurses provided psychological care in the form of reassurance to participants to relieve their anxiety. They also provided requisite information to participants. Also nurses counseled some participants on their lifestyle on areas such as intake of alcohol and smoking during patients' consultation. Some participants were pre-habilitated on how to use crutches to walk after operation. The study also found that nurses provided physical care to participants by ensuring that their personal hygiene was maintained. They also ensured that nasogastric tube and urinary catheter where necessary were passed preoperatively. .

Intraoperatively, the study identified that nurses managed some participants' pain through the use of analgesics and reassurance and therapeutic touch. They also

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monitored participants' vital signs and fluid input. Also, nurses provided the appropriate information to some participants and ensured that participants' safety and infection prevention were maintained. However, the study revealed that some participants sustained minor sores on their legs due to the use of the diathermy machine.

Postoperatively, the study found that nurses monitored and evaluated some participants' vital signs, intravenous fluid input and also managed some participants' body pain, drug effect and wound care. Besides, nurses ensured that participants met the activities of daily living such as self care needs and early mobilization. They also offered appropriate information to enhance health care delivery. The study also found that through family support, participants had proper care such as bathing, washing of sheets and emptying of urinals. The study found out that nurses planned with some participants in their preparation toward discharge to improve caretaker efficiency at home. Nurses educated participants on self care practices, nutrition, medication, wound care and hygienic practices including lifestyle counseling on things such as smoking and alcohol drinking. However, the findings indicated that nurses did not visit participants at home upon discharge. Nurses only reminded participants to take note of the review date and report to the hospital. This led to many participants' wounds being infected. The study found that participants' had mixed perception about the quality of care with regards to clinical outcome and cost of care. Some participants felt nurses did very well for their wounds to heal while others thought nurses did not do well for their recovery. The study also found that participants had real challenges with the cost involved during their care. The study identified participants' suggestion for improvement to be that, nurses should improve on their wound dressing skills, communication and follow up or home visits.

The study was guided by Perioperative Surgical Home (PSH) model as a Microsystems healthcare adapted by Kash et al, (2013). Using thematic content analysis, the

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participants' perspectives of care were based on the feed forward and feedback components of the model. The feed forward deals with data that was gathered during care given process throughout perioperative period. Hence, the study identified patients' assessment and triage such as history taking and physiological assessment and patients' consultation and prehabilitation which comprises; reassurance and provision of information to be consistent with the model. Also, physical care such as personal hygiene and passing of tubes were consistent with preoperative constructs of the PSH model as Microsystems healthcare.

Intraoperatively, the study identified all the emergent themes of the PSH model such as integrated pain management, fluid management, intraoperative information and communication, monitoring of vital signs, participants' safety and infection prevention. Postoperatively, the study identified pain management, early mobilisation through physical care and integrated acute care such as monitoring of vital signs, management of fluid and drug effect, wound care including discharge planning which were consistent with the postoperative constructs of Perioperative Surgical Home (PSH) as Microsystems healthcare model used. Also, with the feedback component of PSH model, participants' perception of care in terms of cost and clinical outcome data with possible improvements were also consistent with PSH model.

However, faith in God during preoperative and postoperative was an additional theme that emerged during the analysis. Participants believed that it was God that protected them throughout the perioperative period. They therefore thanked God for his protection.

CHAPTER FIVE**DISCUSSION OF FINDINGS****5.1 Introduction**

This chapter discusses the key findings of the study taking into consideration the constructs identified in the Perioperative Surgical Home model used as an organizing framework of the study. The main themes that were derived from the study were: preoperative perspectives, intraoperative perspectives and postoperative perspectives of care. These themes were consistent with the constructs of PSH as Microsystems health care used to guide the study. Thus, for the preoperative perspectives nurses assessed surgical patients, consulted patients and provided physical care. Intraoperatively, nurses ensured patients' safety, prevented infection and managed patients pain and fluids. Postoperatively, nurses monitored and evaluated patients' conditions. They also ensured that surgical patients met their daily live activities and sometimes planned with the patient on their education. Patients' perception of nursing care they received and the clinical outcome of their conditions including suggestions for improvement are also discussed. An additional theme that emerged from the study was participants' faith in God throughout the perioperative period.

5.2 Preoperative perspectives

Previous studies indicated that effective preoperative assessment and screening where nurses played active roles, improved the overall patient care efficiency resulting in safe and effective surgery (Royal College of Anaesthesia, 2009; Verma et al, 2011). The current study had revealed that, nurses were actively involved in the preoperative assessment of patients and worked with other team members to ensure that surgical patients had a safe surgery. This supports previous studies that emphasize that preoperative assessment is often done by health professionals such as nurses, doctors, laboratory technicians, anaesthetists and radiologists who work as collaborators to

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ensure that surgical patients are well fit to go through an operation (Austin, Chin Chuan, Krithanrides, 2014; Aziato & Adejumo, 2013). The study also found that through these collaborative efforts by the health professionals during assessment, some patients needed urgent admission and preparation for surgery to save their lives. However, the current study also found that nurses did not take history of many of the patients' conditions preoperatively. It further found that medical officers rather took history of the participants' conditions. Hence, nurses did not gather information from patients about their readiness for the surgery. This could lead to poor planning of care for patients. Indeed, this goes contrary to previous studies that state that when nurses gather enough data from patients about their conditions during assessment it helps to identify patients' readiness and preparedness for surgery based on the patients age, co-morbidities and functional capacity which has great impact on recovery (Abimbola & Oshin, 2010; Akhtar et al, 2013, Mythem, 2011). Notwithstanding this shortcoming, the current study revealed that some nurses asked some patients questions relating to their health conditions and their lifestyle. This made patients to give information that were beneficial to the patients themselves and nursing staff. This confirms previous studies especially those that used the PSH as Microsystems healthcare model that state that when feed-forward information from prior healthcare experience, patients history, physical examination is done, it helps to minimize errors and correct any abnormality detected before surgery (Aziato & Adejumo, 2013; Aditya & Uma, 2011; Knox, Myers, Wilson & Hurley, 2009; Nelson et al, 2011, Samiei et al, 2011). It could, therefore, be deduced that it is necessary to introduce physical assessment into surgical nursing curriculum to equip nurses with the requisite skills to take patients' history and physically examine patients before surgery.

Furthermore, this study found that, nurses involved patients' relatives to provide relevant information on behalf of seriously ill patients to help the health professionals

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provide effective care (Cathy, 2013; Lewis et al, 2009). This practice needs to be continued during nursing care since family members' participation in care has greater impact on surgical outcome (Ministry of Health, 2007). Patients needed to understand the nature and consequences of their proposed surgery prior to giving consent (AAGBI, 2010; Adamson et al, 2012; Babitu & Cyna 2010). However, this assertion was not supported by this study as it was found that many surgical patients did not understand their diagnosis prior to surgery. This implies that it is imperative to let patients or their relatives understand the diagnosis of their conditions and the risk so that they can make an informed consent about whether to proceed with the surgery (Crawford, 2012).

Physiological assessment of surgical patients is crucial to determining the health status of the patients before surgery. The current study found that, nurses took the vital signs of patients such as temperature, pulse, respiration and blood pressure accurately to serve as a base line for treatment or surgery which has been supported by previous studies (NICE, 2008; Pritchard, 2009b). Also, research has shown that when necessary laboratory and radiological examinations of surgical patients are carried out before surgery, it helps to identify and correct abnormalities before surgery (AABI, 2010; Aziato & Adejumo, 2013; Garcia-Migue et al, 2003). This assertion was confirmed by the findings from the current study. The study found that nurses ensured that the necessary laboratory and radiological investigations such as haemoglobin level, blood group, presence of Human Immuno-deficiency Virus, hepatitis B,C status and computerized tomography scan requested for surgical patients were done before surgery (Aziato & Adejumo, 2014c; Bohmer et al, 2012; Hust et al, 2013).

However, the study found that nurses did not disclose to patients the results of these investigations requested as part of their information given regarding their health status. This is contrary to previous studies that indicate that patients have the right to

information pertaining to their health. And also, it is important to explain to patients the essence of monitoring the vital signs since the assessment of such investigations would guide the decision of implementing protocol such as fasting and administration of regular medications which need the full participation of the patients (AAGBI, 2010; Ghana Health Service Patients' Charter, 2002). It was also found in this study that prescribed premedication for surgical patients were reviewed and only essential drugs were given to patients to relieve their pain as supported by previous studies (Crawford, 2012; NICE, 2008). Also, Ian et al., (2011), indicated that when nurses limit patients intake of fluid preoperatively, it reduces anxiety, nausea and vomiting postoperatively. Interestingly, this supports the current findings that revealed that some patients were given intravenous lines for an emergency with only few patients receiving infusion before surgery. However, this could be because such treatment is applied to patients whose conditions need rehydration.

Preoperative anxiety, fear, panic and confusion were exhibited by majority of the patients in this current study due to various factors. This supports previous studies that stated that many factors such as fear of anaesthetic effect, the procedure itself, and the potential outcome of the surgery contribute to surgical patients developing these signs and symptoms when they are about to undergo surgery (Pritchard, 2009a; Degen, Christen, Rovo, & Gratwohl, 2010). Hence, the study revealed that through interactions with the patients, nurses recognized these signs and symptoms in some surgical patients and they reassured them as confirmed by previous studies (Aziato & Adejumo, 2013; Barkat, Ali, Lalani & Malik, 2012; Pritchard, 2009a; Rhode et al, 2006). However, the findings of the current study further showed that some participants did not get the needed reassurance from nurses and that created more anxiety, fear and panic as indicated by a previous study (Tessa, Alison & Wiseman, 2014). It could, therefore, be inferred from the study that nurses need to provide psychological support to all surgical

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patients. Apart from reassurance, the current study had shown that some nurses educated some patients about the theatre environment and how the professionals would be dressed during the surgery. This helped some patients to experience less worry and anxiety about the surgery. This is supported by previous studies that indicated that preoperatively, when nurses talk to surgical patients about theatre environment and provide opportunity for patients to ask questions about anaesthesia and other surgical processes; this could help reduce fear and anxiety (NHS, 2009 & Crawford, 2012). Also nurses should orientate patients to the ward environment before the surgery to help reduce this anxiety and fear preoperatively (Cathy, 2013, Pritchard, 2009a; Rhode et al, 2006).

Research has shown that surgical patients wish that nurses provide information and education in a friendly and professional manner to help to reduce surgical concerns (Schoor, Ulrike, Engelmann & Burkhardt, 2013). This was consistent with the findings of the current study that identified that nurses provided preoperative information and education to participants on shaving, bathing, collecting or buying drugs and undertaking certain laboratory investigations as requested. They also ensured that patients performed these activities (Currie et al, 2011; NICE, 2008; WHO, 2011). As part of preoperative preparation, nurses also ensured that patients removed contraindicated objects such as wedding rings, earrings, beads, and brassier as supported by Cathy, (2013). The study further discovered that nurses maintained patients' comfort and dignity by ensuring that there was privacy during such activities as indicated in earlier studies (Aziato & Adejumo, 2013; NICE, 2008).

This study found that nurses pre-habilitated some patients where necessary such as exercising which helped to prevent postoperative complications. Some patients were also taught how to use crutches to walk after amputation. These findings have been

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supported by previous studies which states that deep breathing and coughing and regular gentle leg exercise would reduce risk of complication such as chest infection, deep vein thrombosis and promote patients' ability to mobility after surgery (Mavidou, Dimitriou, Manataki, Arnaotoglou & Papadopoulos, 2013; NICE, 2010). Also, the study showed that nurses cautioned patients against certain habits such as smoking and drinking alcohol which is believed to enhance speedy recovery and prevent surgical complications postoperatively (Fracyck & Godfred, 2010; Nielsen et al, 2010; Swank et al, 2011).

Nurses informed surgical patients not to eat solid foods the night before surgery. However, previous studies state that since fasting could be difficult to manage and the operation list could be changed or cancelled, surgical patients should not be overstarved (Crawford, 2012, Royal College of Nursing, 2005). This means that nurses at surgical ward were doing away with the routine fasting phenomenon practiced over decades to the modern medical societies where evidence-based practice recommend that at least a clear fluid with carbohydrate could be given to patients before surgery (Angular- Nascimento & Dock-Nascimento, 2010)..

The study found that, some patients exhibited maximum cooperation during care when nurses explained certain nursing procedures to them. This supports previous studies that show that provision of useful information of a nursing procedure to patients has an empowering effect that could enable them comply with treatment or cooperate during such procedures (Mulsow, Feeley & Tierney, 2012; Suhonen & Leino-kilpi, 2006). It can, therefore, be inferred from the study that it is important nurses explain every nursing procedure to patients to capture their cooperation and support during care.

Also, when nurses provide appropriate support and monitor surgical patients during a procedure, it leads to effective care and avoidance of certain nursing care lapses such as

patient failure to bath (Rachel, Charles, Ania & Alison, 2011). Contrary to this assertion, some patients did not take their bath as instructed by the nurses since the nurses were not monitoring their activities as supported by Verma et al, (2011). It is therefore, necessary for nurses to be vigilant and monitor patients to ensure that they carry out important preoperative activities as required. .

5.3 Intraoperative perspectives

Nurses did not inform patients about the use of certain instruments or machines such as the diathermy and that made patients more worried during surgery. Some participants' fears and worries were heightened because of the sound of equipments in the theatre and they thought the doctor was using those equipments to perform the surgery. This is contrary to earlier studies that stated that when nurses give prior information to patients during operation, it assists patients to know what is expected and that would relief their anxiety and worry during surgery (Birgitta et al, 2010; Degen et al, 2010). It could be inferred from the finding that, there was information gap during intraoperative care that the nurses needed to fill especially about the use of certain equipment during operation.

According to Ghana Health Service Patients' Charter, (2002) it is the right of surgical patients to know the health professionals that are to operate on them prior to surgery. Besides, research showed that patients wish to know their health professional providing care to them. This would let patients developed mental strategy that could reduce worry and anxiety during operation (Birgitta et al, 2010; Nikolaji et al, 2013). Interestingly, this contradicted the current study as it was found that, medical officers at the theatre were contemplating on who to perform a procedure to the hearing of the patient. It is therefore, imperative that, nurses should inform patients about the procedure and the person who will perform the procedure to build confidence in the patients (Toussaint, 2012).

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The study found that anaesthetists monitored surgical patients' vital signs and intravenous fluids during surgery to achieve a successful operation as supported by previous studies (Cathy, 2013; Pritchard, 2009b). This means that monitoring of surgical patients vital signs during operation is a common practice that nurses contribute to during care to achieve a successful surgery. Besides, some patients were giving intravenous fluids during surgery. This supports studies that indicate that integrated fluids management during surgery improves patients' health condition after surgery (Knott et al, 2012).

Managing intraoperative pain is very challenging due to the subjective nature of pain (Fraczy & Godfred, 2010). To reduce this challenge the anaesthetist administered analgesics to surgical patients prior to surgery and during operation to reduce pain (Girish, Stephan & Heririk, 2014). Also, during operation, nurses were touching participants, communicating with them to create trust and confidence in them. This therapeutic touch and communication (non-pharmacologic pain management) made patients feel that they were being handled well and this helped to reduce their pain as supported by previous studies (Ann-christin et al, 2013; Kolvered et al, 2012). It means that, nurses contribute to ensure that surgical patients go through minimal pain during surgery. However, some patients went through severe pain during surgery and sustained minor injuries on their legs as a result of inappropriate use of the diathermy machines. This confirms previous studies that indicate that diathermy machine should be used with care since it can cause injuries or death to patients or staff (Spruce & Braswell, 2012). It is suggested that nurses should not allow any part the patients' body to touch any earthed object such as the trim of the operating table, or intravenous drip stand. Besides, a material such as draw sheet or blanket should be placed between the patient and the return electrode mat to prevent these injuries to patients (AORN, 2009; Rothrock & McEwan, 2011). The current study observed that some nurses did not

remove the diathermy machine early even though the patient reported pain intraoperatively. This finding support some previous studies that report that surgical patients wish that nurses could listen to their concerns and respond to their concerns in a positive manner (Ann-christin et al, 2013; Kavmackci et al, 2006). This therefore, suggests that, nurses should listen to patients and respond to them in order to prevent injuries to patients during surgery.

Surgery is a worrying phenomenon, therefore, ensuring patient safety and prevention of infection during operation is paramount to successful surgical outcome (Leape & Berwick, 2009; Vaismoradi, Salali & Marck, 2011). Thus, nurses adopted strategies that ensured participants safety. For example, they assisted participants to lie on the operation table and positioned them comfortably on the operating table to ensure that they did not fall. They also assisted some patients after the surgery to prevent injuries (Butterwork, Jones & Jordan, 2011; Kohlbrenner, Whitelaw & Cannaday, 2011). Nurses also, ensured a clean surgical site using skin disinfectant, draped and wore gloves during surgery to prevent infection. These activities supported previous studies that state that nurses are required to comply with a number of good practices such as ensuring clean environment, gloving and using skin disinfectant to clean patients' surgical site to ensure sterile field before surgery (AORN, 2014; Pratt et al, 2007; Kelvered et al, 2011). This practice ensures that surgical patients do not get post-operation complications such as wound infection.

5.4 Postoperative perspectives

Postoperatively, nurses monitor patients' vital signs, pain and fluid input and evaluate patients' condition after operation to ensure that patients return to normal activities (Janine & Teresa, 2010). Thus, it was discovered that, nurses monitored surgical participants' vital signs, administered analgesics to reduce pain and reported any

abnormality detected for correction as supported by previous studies (Ahrens, 2008; Rogers, Dean, Hwang & Scott, 2008). However, the study revealed that nurses were not monitoring patients' vital signs at regular intervals as required immediately after surgery (Zeite & McCutcheon, 2006). It is therefore, necessary that nurses monitor and evaluate the progress of patients' condition regularly to detect any changes since surgery and anaesthesia may have an effect on their vital signs.

The current study discovered that nurses monitored and evaluated intravenous fluids that patients were receiving. This finding supports previous studies that state that it is the responsibility of nurses to monitor surgical patients' intravenous fluids to prevent any adverse events. Regular monitoring would ensure safe administration of intravenous fluid (Health Protection Scotland, 2012; RCN, 2010). Further studies indicate that patients that underwent non-gastrointestinal surgery could be encouraged to take in early oral fluid to enhance recovery, early ambulation, bowel movement and decrease intravenous fluid administration (Ahmad & Turki, 2013; Yin et al, 2014). Contrarily, the current study revealed that nurses did not encourage early oral fluid intake among non gastrointestinal patients even though they were thirsty.

The nurses administered analgesics as prescribed to patients who were in pain and also taught them how to position themselves on bed to reduce pain as supported by previous studies (Aziato & Adejumo, 2014; Weiran, Zhang & Mu-lian Woo, 2013; Zambouri, 2007). Also, nurses detected that some patients were in pain and reassured them. This supports a previous study which stated that in handling postoperative pain, patients desire nurses to demonstrate confidence and reassure them to reduce their anxiety, promote their physical activity and reinforce their self management strategies (Leonard, Tousignant-Laflamme & Mercier, 2013). However, some participants in the current study shared similar experiences with a previous study when nurses failed to respond to

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patients' call when they were in pain. This attitude made some patients to endure unnecessary pain (Aziato & Adejumo, 2014; Maier, Nestler & Richter, 2010). It is necessary that nurses respond to patients who are in pain since each person had different level of threshold for pain.

Due to the effect of anaesthesia, postoperative patients do not make meaning of immediate postoperative information given to them (Arested & Berg, 2013; Blandford, Gupta, Montgomery & Stocker, 2011). In congruence with this, this study found that some patients failed to understand postoperative information given to them during the recovery period. This could be due to dizziness and drowsiness that participants experienced as a result of anaesthetic agent. This could mean that, nurses do not have patience to wait for full recovery of surgical patients before instructions are given. It is imperative that, nurses are educated to know when to give post-operation instructions to patients to enhance their understanding and response.

In order to maintain patients' dignity and respect during nursing care, it is important to provide privacy during care. It is also important to ensure effective nurse-patient interaction through which nurses would be able to disclose the state of patients' condition to them (Fritz & Them, 2012; Stephanine & Zoe, 2015; Sieger, Reiko et al, 2013). Nurses ensured that participants' privacy and respect was maintained during wound dressing. Also, through effective and efficient interaction with some participants during wound dressing, nurses informed them about the state of their wounds. As a result, some surgical patients were informed to procure medicine that could be used to dress their wounds due to infection.

The study found that nurses assisted the seriously ill patients to bath on bed and also changed patients' bed sheets whenever the sheets were dirty to promote comfort and dignity. Consistent with this finding, previous studies show that nurses do assist patients

to bath on bed and also change patients' dirty linen to improve and promote their well being (Al-Zaru et al, 2011; Beth Happ et al, 2010; Khan et al, 2006).

Family support during hospitalization is an indispensable activity in providing good nursing care to patients especially within the Ghanaian surgical context (Aziato & Adejumo,2014). Nurses work with family members as partners in carrying out some of the nursing care (Boltz, 2012). Hence, family members assisted their loved ones to bath, collected or bought medicine at the pharmacy, paid their hospital bills and prepared food and fed their relatives (Aziato & Adejumo, 2014; Osso, 2012). They also served urinals and bedpan and washed their relatives' bed sheets hence, corroborating a previous study (Hoffman et al, 2012). This means that family members play a unique role in caring for surgical patients. As a result, it is important to educate family caregivers to improve their skills to perform some of these activities (Levine, Halper, Peist & Gould, 2010).

Even though some patients had difficulties in ambulating, nurses encouraged them to walk regularly, breathe deeply including coughing exercise to improve their well being and prevent postoperative complications (Kibler et al, 2012; Masood, Zubia & Abdullah, 2006; Clara, 2010). Nurses advised patients to stop certain practices such as taking alcohol or the local drink ("Pito") and smoking cigarette after discharge in order to promote their speedy recovery at home. Besides, nurses educated some patients on the need to keep their wounds dry to prevent infection. These findings support previous studies that indicate that nurses often planned with patients and their family members during discharge and educate them to avoid factors that can negatively affect recovery. They also educate patients on proper personal hygiene and wound complications (Berg, Arestedt & Kjellgen, 2013; Chuan et al, 2014; Wong et al, 2012). Proper nutrition promotes speedy recovery and enhances wound healing (Foust, Vuckovic & Henriquez,

2012). However, the study indicated that nurses did not stress the importance of nutrition to some patients even though some were encouraged to take fruits, vegetables, fish and meat upon discharge to promote wound healing. It could be inferred from the study that nurses did not educate all patients equally on discharge.

Educating discharged patients on how to take their prescribed medications at home to enhance speedy recovery is important since failure to do so could lead to patients taking overdose or under dose of such medicines (Foust, Vuckovic & Henriquez, 2012). Besides, it is important to educate patients on the side effects of these medicines (Ann-Schoofs et al, 2009; Diane, Mnistae & Kathryn, 2011). However, the study revealed that some patients were not educated on how to take the medicine at home and this compelled some of them to follow instructions on the label. Besides, patients were not educated on the side effects of these medications. It is good nurses and pharmacists take their time to educate discharged patients on their prescription instructions to avoid inappropriate usage at home.

The study revealed that patients were informed of their scheduled days for wound dressing on the ward without educating them on how to change their wound dressing when necessary. Besides, patients were not educated on some of the signs of wound infection. These findings confirm previous studies that indicate that ineffective teaching of surgical patients upon discharge about wound care could lead to patients lacking the requisite knowledge and skills on how to care for the wound at home leading to complications (Pieper et al, 2007; Tanner, Padley & Davey, 2012; Sanger et al, 2013). It is therefore mandatory that nurses spend much time in educating discharged surgical patients to equip them with the necessary knowledge and skills to enable them handle their wounds properly at home. It is imperative that nurses apply the principles of aseptic technique such as wearing a mask, gloves and use of sterile dressing during

wound dressing to prevent infection (AORN, 2010). Contrary to this, the current study showed that some nurses did not wear mask or dress wounds well to remove any accumulated fluid. This practice compounded some the participants' problems contributing to their wound infection.

Nursing is a continuous process and there is the need to visit discharge patients at home to fine out how they are doing. However, nurses at the surgical unit did not visit participants at home. Many of the patients stated that some nurses told them their wounds were infected when they reported to the ward for dressing. This confirms previous studies that indicate that due to the untimely and infrequent or lack of follow up visits that nurses do, many patients get wound infection at home. Wound infection puts much burden on family members who lack the requisite knowledge to handle it leading to more complications (Kazaure, Roman & Sosa, 2012; Sanger et al, 2013 & Saunders et al, 2012). To close this gap in the nursing care, it is suggested that nurses should incorporate days in their duty schedule to visit discharged patients to assess their environment and provide education as necessary (Mottram, 2011). Also, nurses could liaise with the community health nurses to continue caring for patients at home since failure to do so could affect recovery and cause readmission (Wennstrom et al, 2010).

In surgery, patients' perspectives about care are relevant as a key outcome in areas such as health related quality of life and satisfaction. Hence, some participants were happy and thankful to some nurses for being polite in their communication and interaction during care confirming previous studies that show that good nurse-patient interaction and communication are the key component of quality care since it establishes a healthy relationship that allows participants to voice their concerns freely (Fleisher et al, 2009; McMurray, Johson, Patterson & Griffith, 2007; Seiger, Fritz & them, 2012; Stephanie & Zoe, 2015). However, the study also found that some nurses were using abusive

language for patients and were not ready to listen to their concerns as stated in previous studies (Ingna et al, 2011; Norazliah, 2012). Besides, some patients were full of praises that some nurses were able to dress their wounds skillfully.

Skillful wound dressing is supported by a previous study (Shawa, 2012). It was also reported that some patients were happy to have resumed their activities of daily living which is supported by previous studies that show that patients desire to get good outcomes such as regaining their normal activities (Grøndah, 2012; Pusic & Ainndrea, 2014). That notwithstanding, many of the patients felt nurses did not handle their wound properly and they had wound infection. The study found that some nurses refused to dress some patients' wounds and such patients perceived nursing care as poor.

The study found that patients had serious challenges with the cost of care even though many of them had registered with the national health insurance scheme. The scheme covered areas such as in-patient bills, some medicines and other expenditures. This supports a previous study which stated that cost of hospital care extends well beyond cost of medications, surgery and related treatment making surgical patients suggest the need for assistance in dealing with indirect cost such as transportation and feeding (Kim, 2007). It could be inferred from the study that reducing hospital cost does not depend only on the number of days on admission as the PSH model suggests. The reduction in hospital cost depends on multiple factors.

5.4 Faith in God

In the Ghanaian culture and for that matter African society, people attached importance to spirituality and therefore have certain beliefs and faith in God in every aspect of their life. As a result, they tend to seek for spiritual help through various avenues such as prayers and consultations with religious leaders for good health both at their community

level and in the hospital. Religion is therefore an indispensable component of the health delivery system (Abiodun & Umoh, 2011; Azongo & Adadow, 2015). It is noted that patients' religious background need to be taken into consideration when nurses are preparing surgical patients for surgery (Jan et al, 2012). Interestingly, this assertion was not supported by the study as it was found that, nurses neglected patients' religion during preoperative preparation even though, patients recognized its importance to their successful surgery by offering thanks and praises to God. However, this confirms a previous study that indicated patients' relatives prayed for them to have successful surgical experience. This indicates that religion is not regarded by health care professional during care (Aziato & Adejumo, 2014). It is therefore necessary to incorporate religion into the health policies in order to achieve good health for patients.

In summary, the chapter discussed the findings from the interviews of surgical patients' perspectives of perioperative nursing care. The discussion focused on the participants' perspectives of preoperative nursing care, intraoperative nursing care as well as their perspectives of postoperative nursing care. The discussion also considered the constructs of the Perioperative Surgical Home model as Microsystems healthcare used in guiding the study. The constructs of the model were consistent with the themes generated. However, the constructs were not consistent with other findings such as faith in God.

CHAPTER SIX**SUMMARY AND CONCLUSION****6.1 Introduction**

This chapter summarizes the study and states the implication for nursing practice, research, nursing education and policy as well as limitations of the study. Also some recommendations are given to serve as a guide for ensuring delivery of better nursing care to surgical patients throughout the perioperative period.

6.2 Summary

The study explored the perspectives of surgical patients on perioperative nursing care received at the Regional Hospital, Bolgatanga. The study was guided by the Perioperative Surgical Home as Microsystems healthcare model adapted by Kash et al, (2013). A qualitative exploratory approach and purposive sampling technique was adopted to recruit participants. The study involved Fifteen (15) participants that lived within the Bolgatanga municipality and had received nursing care at the Regional Hospital, Bolgatanga and were discharged. In-depth interviews were conducted using semi-structured interview guide. Interviews were audiotaped, transcribed and analysed concurrently. Data collected were analysed using the principles of thematic content analysis taking into consideration the constructs of the PSH model as a guide. The main themes that emerged were consistent with the PSH model such as preoperative perspectives with the sub-themes being patients assessment and triage, patients' consultation and prehabilitation and physical care, Intraoperative perspectives with the sub-themes being, intraoperative information, monitoring of intraoperative vital signs and intravenous infusion, integrated pain management, safety and infection prevention and postoperative perspectives with the sub-themes being monitoring and evaluation, activities of daily living, discharge planning and perceived quality of care. However an

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additional theme that emerged from the data was faith in God. The study provided an insight about the participants' perspectives of perioperative care

Exploring patients' perspectives on preoperative care, the study found that nurses did not take history from many of the participants even though they monitored participants' vital signs and ensured that their laboratory and radiological investigations were done. Nurses also administered premedication and intravenous fluids to some patients as prescribed. However, it was discovered that nurses failed to deliver effective information to participants during care to help them make an informed decision. Provision of the necessary psychological support in the form of reassurance, education and orientation to the ward environment were done to some extent. However, some participants stated that they did not receive adequate information from the nurses hence their anxiety and fear was heightened. As a result, some participants built their hope after seeing others undergo successful surgery. It was realised that nurses did not provide the needed spiritual support to participants in the form of prayers. This made participants to perform a self prayer before surgery. Some participants were pre-habilitated to increase their mobility after the surgery. It was revealed that nurses counseled some participants on smoking and alcohol intake. They counseled some participants to breath deeply, exercise and cough regularly to reduce postoperative complications.

Preparing surgical patients physically for surgery involved nurses shaving and bathing patients where necessary. However, the study found that nurses told some participants to shave and bath themselves with soap and water which some participants did not comply with. Besides, nurses performed other care activities such as catherization and passing nasogastric tube where necessary before surgery.

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Exploring the intraoperative perspectives of surgical patients, the study found that nurses provided some requisite information about the use of certain gadgets especially the diathermy machine and its effects. However, some participants were not told about use of the machine and that made them feel that the surgeon was using a machine to operate on them; hence, making them more worried. Also the study revealed that a participant sustained minor injuries on his leg due to the diathermy machine. Participants encountered minimal pain during surgery due to the anaesthetic agent that was administered. Nurses also used touch and verbal communication to let participants experience less pain during surgery. It was found that nurses ensured participants safety during surgery by ensuring that participants were well positioned on the operating table and were assisted to lie and get up. Some participants were even lifted from the operating table to the stretcher. Nurses ensured that participants were draped and the surgical site was cleaned with antiseptic solution to prevent infection. However, some participants experienced fear and anxiety when surgeons were deciding on who should operate based on experience.

Postoperatively, the study revealed that nurses monitored and evaluated the participants' vital signs where certain abnormalities such as high body temperature and blood pressure were detected and corrected. However, some participants' vital signs were not monitored at regular intervals as expected. It was revealed that nurses monitored participants' intravenous infusion and drugs but failed to encourage participants to take oral fluids such as water even though some participants were thirsty and bowel sound had returned. It was also found that participants' pain relief was achieved through the administration of prescribed analgesics, bed rest and proper positioning on bed. However, some participants decided to endure their pain throughout the night just because some nurses were not responsive to their call. The study revealed that participants experienced much disappointment when nurses were giving them

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instructions whilst they were experiencing the anaesthetic effects. Consequently, they could not understand whatever the nurses were saying. Nurses provided privacy during wound dressing but failed to educate participants on the state of their wound healing. The study identified that nurses ensured few participants personal hygiene and changed bed sheets. However, it was found that many of the participants' relatives assisted with bathing, washing of bed sheets and serving of bedpan and urinals. The relatives also provided financial support and ran many errands for patients.

Again, it was found that some nurses encouraged participants to ambulate by walking to promote faster recovery. Despite these efforts some participants lamented that some nurses used abusive language during care. It was found that upon discharge, nurses educated participants on proper nutrition, exercise, rest, and maintenance of personal hygiene at home to promote speedy recovery. Others included how they could take their medications at home. However, nurses failed to educate participants on the side effects of these medications. Besides, participants were not well educated on how to identify danger signs of wound infection and how to change the dressing when necessary. Also, it was found that some nurses dressed the wounds without wearing mask. Consequently, these activities led to many of the participants' wounds being infected.

The study also showed that none of the nurses at the surgical unit paid a home visit or made a phone call to any of the participants. It was also found that many participants stated that their wounds were infected due to their inability to come for the daily dressing.

Regarding the participants perception of the quality of care they received in terms of the clinical outcome of their conditions, the study revealed that participants had mixed feelings about the care. Some participants felt the nurses did well for them to regain

their health so that they can continue their work at home whilst others felt that the quality of nursing care was poor.

6.3 Implication for Clinical Nursing Practice

Gathering necessary health data from patients allows nurses to plan effectively for their treatment. Thus, nurses should always take patients' health history to serve as a baseline data that can be used to plan for their care. Information delivery to patients has an empowering effect on patients' cooperation during nursing care. As a result, nurses should always provide effective information to patients during care. Due to inadequate nursing staff at the various hospitals, family members provide support during care by performing certain activities such as collection of drugs at the pharmacy and buying items for use during care. This implies that nurses need to appreciate the contributions from the family members and rather encourage and involve them in the planning process for them to be well informed and contribute positively during the care process.

An injury to the surgical site during physical preparation could promote infection after surgery. Hence, nurses must carefully shave patients' surgical site by avoiding a cut in order to prevent wound infection. Nurses can also coach ambulant patients to perform certain activities such as shaving and bathing and must ensure that patients perform the task correctly. Health education is an effective tool in health care delivery. As a result, nurses should intensify their education on avoidance of cigarette smoking, alcohol and cola nuts during care to promote good health. In nursing practice, psychological care is very important; hence nurses should reassure and orientate patients to the ward environment to reduce patients' anxiety, fear and panic. Also during surgery, patients are not expected to encounter harm. As a result, nurses should work effectively with other surgical team members to ensure that patients are not harmed during surgery.

Nurses must ensure that the aseptic techniques are applied during care to prevent infection.

Postoperative monitoring and evaluation of patients is very important in nursing practice. Hence, nurses should monitor postoperative patients regularly to assess the progress of patients' conditions. They should encourage patients', especially nongastrointestinal postoperative patients, to take oral fluid within the shortest possible time since some patients often feel thirsty. Nurses should improve on patients' transition home planning by involving patients' relatives during discharge planning since they would care for the patients at home upon discharge. Efforts should be made to visit patients at home after they have been discharged. Providing spiritual support to patients during nursing care is crucial for a better health recovery. Hence nurse should consider the spiritual needs of surgical patients and always invite the hospital chaplain or Imam to pray with the patients before they enter for surgery.

6.4 Implication for Nursing Education

Education in nursing is the central part of nurses' strength of knowledge to impact care for patients. Nurses play a very important role in the education of patients and their relatives due to the link they have between patients and the other health care providers especially the surgical team. Nurses interact with the patients throughout their admission on the ward and share a lot of concerns with these patients about their health. Hence, for nurses to effectively achieve the desired outcome of patients there is the need to be well equipped with the necessary knowledge through education. As a result there will be the need to include the role of family care giver in perioperative nursing care. This will enhance students' knowledge on importance of family members in the care process. Also effective communication skills and nurse-patient relationship should

be taught at the health training institutions in the country for nurses to develop effective communications skills and interaction during nursing care. The hospital authorities should organize in-service training for nurses to equip them with skills of wound dressing. Patients and their relatives should be educated on proper care of their wounds at home.

6.5 Implication for policy

The hospital matron and the medical superintendent should review the existing nursing care policies with particular reference to the feedback component of the PSH model as Microsystems health care which deals with the cost, quality (Clinical Outcome) and patients' perspectives that need improvement for effective nursing care. Also feedback mechanism should be put in place to regularly assess the healing process and the quality of care at the surgical unit. Even though the national insurance scheme had covered many aspect of surgical care, it would be better if government could extend the insurance premium to cover certain laboratory and radiological examinations that surgical patients need to do to confirm their diagnosis. This would help many patients who need surgical attention but due to high cost, remain at home.

6.6 Avenues for Further Research

Based on the findings of the study, further studies could be conducted on the major themes at a different surgical unit of the hospital to gain an in-depth understanding of other patients' perspectives. Also, research could be conducted on other areas such as;

1. Nurses' perspectives of the perioperative care they render to patients using the PSH model as a guide.
2. A research on the use of theatre equipment and their impact on patients' physical and psychological health at the surgical unit.

3. A research on the relationship between patients, nurses and family members and their responsibilities during perioperative nursing care that promote patients healing process.
4. A research on spirituality and the healing process of surgical patients throughout the perioperative period to unearth its significance in nursing care.
5. Further research could be conducted to explore surgical patients' perspectives on quality of nursing care in relation to clinical outcome and areas that need improvement.
6. A research to assess the behavioral factors that contribute to wound infection on the ward.

6.7 Limitations of the study

The findings of this study may not be generalized due to the small sample size used in qualitative studies. However, the findings of the study may be transferred to a similar context since the demographic data and research setting has been described. Also it would be difficult to replicate this study due to the unique accounts of the individual participants in the study.

6.8 Conclusion

In conclusion, the study explored the Perspectives of Surgical Patients on Perioperative Nursing Care at Regional hospital, Bolgatanga, in which PSH as a Microsystems healthcare model adapted by Kash, et al, (2013) was used as an organizing framework. The aim of the model is to achieve better health, better health care and reduce cost through continuous improvement for all surgical patients. Despite the fact that nurses did their best to achieve these aims, the findings from the study indicated that nurses exhibited poor attitude such as poor communication toward patients during care. Nurses

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also neglected the spiritual needs of surgical patients throughout the perioperative period. Nurses shifted some of their responsibilities such as bathing, shaving, serving of bed pan and urinal to the family members. Furthermore, nurses were not visiting discharged patients at home. Aside that, most of the patients wounds were infected as a result of poor nursing care. There was inappropriate usage of theatre equipments which resulted in a patient experiencing unnecessary pain and minor injuries. Nurses provided inadequate information and education throughout the perioperative period. Nurses were not conducting physical assessment and for that matter, history taking to gather data that could have been used to plan for the care of the patients. To improve on the nursing care, authorities should organize in-service training, workshops for nurses to improve on their communication skills and wound dressing skills to ensure that there is effective and efficient nursing care.

The PSH model is a useful model for ensuring better health care for patients. When it is duly followed, it gives a clear focus of care that the surgical team members are to follow to provide effective and efficient care to patients throughout the perioperative period. In the Ghanaian context, it is believed that people have faith in God and often solicit for spiritual support through prayers in every activity. Hence, the PSH model should have a spiritual domain that can give room to the religious leaders to meet spiritual needs as part of care to the patients before, during and after surgery.

6.9 Recommendations

Based on the findings of the study, the following recommendations were made:

The Hospital Authorities

1. The surgical ward matron should ensure that nurses involve patients in the planning of the care. This would allow patients to make informed decisions based on their diagnosis and treatment.
2. The training unit of the hospital should conduct in-service training on physical assessment for nurses so that they can conduct physical assessment and take patients health history to gather data that could be used as a baseline data for continuous treatment and monitoring.
3. The matron should ensure that nurses at the surgical unit involve patients' relatives during discharge planning to prepare them effective for home care.
4. The hospital matron should ensure that nurses avoid the use of medical "jargons" and use simple language during education to enhance patients understanding.
5. The hospital administration should review the status of their theatre equipments used for surgery to make sure they are working properly.
6. The training unit of the hospital should also organize in-service training programmes on the use of the diathermy for theatre nurses so that they can learn to operate it since it improper use could be harmful to staff and patients.
7. The management of the surgical unit at Regional Hospital should organize a program plan that could include mechanisms such as home visits to monitor discharge patients health status at home.

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8. The ward matron must ensure that nurses apply their basic aseptic techniques during care to prevent infections at the ward.
9. The ward matron must also ensure that nurses intensify their information delivery and education to surgical patients throughout the perioperative period.

The Ministry of Health / Ghana Health service.

1. Ministry of Health should introduce physical assessment as a course into surgical nursing curriculum of the diploma awarding health training institutions. This would help develop nurses' skills in conducting physical assessment for patients.
2. The Ministry of Health and Ghana Health Service should coordinate and train more perioperative nurses to support the current staff strength of perioperative nurses.
3. The government of Ghana should review the National Health Insurance premium to cover major laboratory and radiological examinations.

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APPENDIX A: DEMOGRAPHIC INFORMATION

Code number.....

1. Age : 18-29 []; 30-49 []; 50-69 []; 70 and above []
2. Sex: Male []; Female []
3. Marital status: Married []; Divorced []; Not married []
4. Religion-----
5. Level of education-----
6. Language (s) spoken fluent-----
7. Occupation.....
8. Place of residence -----
9. Type of surgery (emergency/ planned) -----

APPENDIX B: INTERVIEW GUIDE

1. Please can you share with me your story after you were told that you were going to be operated upon?
So what happened next?

2. What did the nurses do for you before the surgery?

Probe –Assessment

Vital signs
Laboratory investigations
Education
Premedications

3. Can you share with me your story when you were sent to theatre?

Probe

Psychological care
Communication
Safety
Treatment

4. What did the nurses do for you after your operation?

Probe

Pain management
Vital signs
Exercise
Wound care, Hygiene needs, Education

5. What did the nurses tell you to help you care for yourself at home?

Probe

Period of education
Nutrition
Rest and sleep
Wound care
Pain management

6. Is there anything else you will like to share with me?

APPENDIX C: CONSENT FORM

Title: Exploration of Surgical Patients' Perspectives of Perioperative Nursing Care at Regional Hospital, Bolgatanga.

Principal Investigator: Adugbire Atinyagrika Bernard

Address: School of Nursing

University of Ghana

Legon

P.O.Box LG 43

Tel:0208976915

E-mail: adugbirebernard@yahoo.com

General Information about Research

The study aims to explore your Perspectives of nursing care you received before, during and after the operation at the Bolgatanga Regional Hospital. I will like you to provide me with information on the nursing care you received before, during and after the operation. I will have a chat with you which will last between forty five to ninety minutes. I will use English language or Grune depending on the one that you can speak well. You are free to share with me the information that you have concerning the questions that I ask you. The interview will be related to your opinions on the nursing care you received before your operation, the nursing care you received when you were in the theatre, the care you received after your operation and your stay on the ward. You will also be interviewed on how you were prepared by the nurses before you were discharged home. You will be asked to sign or thumbprint a consent form before the interview begins. The interview will be recorded with a tape recorder with your permission.

Possible Risks and Discomforts

It is not expected that you would encounter any harm during your participation in the study. However, if you experience some form of tiredness and emotional distress during the

interview, the interview will be stopped and we will continue when you wish to do so or on another day. Besides, the services of a counselor will be made available at no cost to you when you experience emotional distress during the interview (counselor's name: Apasera Eziekel, 0209421049).

Possible Benefits

There are no direct benefits to you as a participant. However, your participation in the study will enable the researcher understand the kind of nursing care patients on the surgical ward receive from nurses. It will also provide the public health nurse an insight of surgical patient needs at home.

Confidentiality

The conversation between you and I will be recorded. However, your name and any other information that might disclose your identity will not be recorded. You will be given a code number that will be attached to the information you will give to me during the interview. The information will be locked and it is only my supervisors or those overseeing my work that can have access to the information you will provide to me.

Compensation

You will not be given any money but a bottle of Malta Guinness drink and biscuit will be given to refresh you after the interview.

Voluntary Participation and Right to Leave the Research

Your participation in this study is voluntary. You have the right to withdraw at any time you want without necessarily given any explanation or reason.

Contacts for Additional Information

Adugbire Atinyagrika Bernard

School of Nursing, University of Ghana, Legon, Accra.

Phone Number: +233247208922

Email: adugbirebernard@yahoo.com.

Dr. Lydia Aziato

School of Nursing, University of Ghana, Legon, Accra

Phone Number: + 233208552719

Email: laziato@yahoo.com

Dr. Florence Dedey

Department of surgery

Ghana Medical School

Korle-bu teaching hospital

Email: flodedey@yahoo.com

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.mimcom.org

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title “Exploration of Surgical Patients’ Perspectives of Perioperative Nursing Care at the Regional Hospital, Bolgatanga” has been read and explained to me. I have been given an opportunity to

Patients' Perspectives of Perioperative Nursing Care

have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date

Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name Signature of Person Who Obtained Consent

*Patients' Perspectives of Perioperative Nursing Care***APPENDIX D: GENERAL PROFILE OF THE PARTICIPANTS**

Pseudo-nyms	Age	Sex	Marital status	Religion	Education background	Language spoken	Occupation	Place of residence	Type of surgery
MP1	30	M	Married	Christian	JSS	Grunne	farmer	sumbrungu	Hernioraphy
MP2	65	M	Married	Traditionalist	Illiterate	Grunne	Farmer	Bolga	Hernioraphy
MP3	24	M	Not married	Muslim	JSS	Grunne	Carpenter	Zongo	Appendectomy
FP4	35	F	Married	muslim	Tertiary	English/ Grunne	Teacher	Soe	Appendectomy
MP5	37	M	Married	Christian	Illiterate	Grunne	Carpenter	Soe	Hernioraphy
FP6	35	F	Married	Christian	Tertiary	English/ Grunne	Teacher	Zaare	Appendectomy
MP7	55	M	Married	Traditionalist	Illiterate	Grunne	Farmer	Zorogo	Hydrocelectomy
MP8	36	M	Married	Muslim	tertiary	English/ Grunne	Teacher	Yurigo	Hydrolectomy
MP9	45	M	Married	Christian	JSS	Grunne	Farmer	Soe	Herniorraphy

Patients' Perspectives of Perioperative Nursing Care

FP10	55	F	Married	Muslim	illiterate	English/ Grunne	Business	Bongo	Amputation (leg)
FP11	55	F	Not married	Christian	Tertiary	English/ Grunne	Teacher	Soe	Lipoma
FP12	23	F	Not married	Christian	Tertiary	English/ Grunne	Teacher	Winkongo	Lumpectomy
FP13	56	F	Married	Traditionalist	Illiterate	Grunne	Farmer	sherigu	Herniorraphy
FP14	45	F	Married	Christian	Illiterate	Grunne	Farmer	Bukere	Amputation (leg)
FP15 mmmmmm mmmmmmmm	25	F	Not married	Muslim	Tertiary	English	Teacher	Daporetind-ongo	lumpectomy

APPENDIX E: SUMMARY OF THEMES

Themes	Sub-themes
Preoperative perspectives	Patients' assessment and triage, patients' consultation and pre-habilitation, physical care
Intraoperative perspectives	Intraoperative information, monitoring of vital signs and fluid, integrated pain management, safety, infection prevention
Postoperative perspectives	Monitoring and evaluation, activities of daily living, discharge planning, and perceived quality of nursing care.
Faith in God	Prayer

ETHICAL CLEARANCE**NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH**

Established 1979

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INSTITUTIONAL REVIEW BOARD

Post Office Box LG 581

Legon, Accra

Ghana

My Ref. No: DI.22

Your Ref. No:

6th May, 2015**ETHICAL CLEARANCE****FEDERAL WIDE ASSURANCE FWA 00001824****IRB 00001276****NMIMR-IRB CPN 099/13-14 revd. 2015****TORG 0000908**

On 6th May 2015, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting conducted continuing review and renewed your protocol titled:

TITLE OF PROTOCOL : Exploration of Surgical Parents' Perspectives of Perioperative Nursing Care at the Regional Hospital

PRINCIPAL INVESTIGATOR : Adugbire A. Bernard, Mphil Cand.

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 5th May, 2016. You are to submit annual reports for continuing review.

Signature of Chair:

Mrs. Chris Dadzie
(NMIMR – IRB, Chair)

cc: Professor Kwadwo Koram
Director, Noguchi Memorial Institute
for Medical Research, University of Ghana, Legon

INTRODUCTORY LETTER FROM THE DEPARTMENT

SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA
LEGON

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SON/PT

A-17



P.O. Box LG 43
LEGON, GHANA

April 2, 2014

Our Ref:.....

Your Ref:.....

The Medical Director
Regional Hospital
Bolgatanga
UE/R

Dear Sir,

INTRODUCTORY LETTER

I write to introduce to you Mr. Adugbire Atinyagrika Bernard, an M'Phil student of the University of Ghana, School of Nursing. He is seeking your permission to collect data for his research on the topic **"Exploration of Surgical patients' perspectives of perioperative nursing care at the Regional Hospital, Bolgatanga."**

I would be grateful if you could kindly assist him with the information that he may require for his thesis.

Thank you.

Yours faithfully,

Dr. Lydia Aziato
LECTURER