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Patient perception and assessment of admission to acute cardiac care unit

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Abstract

Background: To provide equal care and treatment of cardiac patients it is common practice to base the work on clinical guidelines. These guidelines mainly cover the provider perspective rather than the patient perspective. Patient satisfaction, however, is an important parameter within quality development of professional services in hospitals. Patient satisfaction is, i.e. connected with the amount of information provided to the patient and how much patients are involved in their care and treatment. This is also assumed to apply within cardiac practice. However, in relation to acute admission there is no clear picture of the patients' real preferences; likewise there is no documentation whether these preferences correspond with the nurses' assumptions.

Aim: The aim of this study was primarily to investigate what preoccupied patients admitted to cardiac care units with acute coronary syndrome in connection with the first hours of their admission, and secondly to discuss these perceptions in relation to the nurses' perception from a previous pilot study.

Method: A qualitative descriptive analysis of 30 semi-structured interviews was carried out to investigate the patient perception and assessment of care and treatment by acute admission.

Results: The patients included 22 men and 8 women with an average age of 59 (SD=11.5) years. In all, 5 themes: efficiency, professionalism, pain management, compassionate nursing and information were considered essential and all together they expressed what preoccupied the patients.

Conclusion: It is possible to show what the patients think is important, also during acute admission. In general, the patients felt they were in good hands. Most important was the care providers' competencies and that they "knew their job". The patients' experience of pain management might suggest insufficient care and treatment within this field.

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Keywords: Acute coronary syndrome; Patient perspective; Patient experiences; Patient satisfaction; Qualitative research; Nursing

1. Introduction

To provide equal care and treatment of cardiac patients it is common practice to base the work on clinical guidelines [1,2]. The Danish Cardiologic Society has prepared a joint consensus report on guidelines which applies to patients with

acute coronary syndrome (ACS) [1]. The guidelines mainly cover the provider perspective rather than the patient perspective [2]. Patient satisfaction, however, is an important parameter within quality development of professional services in modern hospital care [2–5]. Patient satisfaction is, i.e. connected with the amount of information provided to the patient and how much patients are involved in their care and treatment. This is also assumed to apply within cardiac practice. However, in relation to acute admission there is no clear picture of the patients' real preferences.

Previous studies show that the patients' individual perception of information varies. Often the patients are content

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with verbal or oral information although they have not been informed about the samples and examinations they have had taken [6–8]. Patient participation in own care is based on a presumption that the patients in general want to participate and that they benefit from having a more active role in their own care and treatment [9].

The question, however, is how information and participation are experienced in the acute admission and to which extent the patients want to be involved. One can imagine that it is difficult to involve the patients especially in the acute phase of their admission as they might be physiologically unstable which results in complex treatment and care procedures and which requires fast decisions. [1,10,11]. It is thus unclear whether patients in the acute phase are able to and can benefit from being informed and involved. It is only scarcely described whether patients, in the acute phase, notice the nurses' care and what it means to them.

1.1. Patient perspective versus provider perspective

A Swedish study [12] has shown that nurses in the intensive care unit perceive themselves as an auxiliary arm to the doctor's medical practice and thus they do not show compassionate nursing. Several of the nurses do not consider compassionate nursing and it does not interest them that each patient is unique and has different problems and needs. They work by the device "taking over" the patient's situation thereby making some patients hesitate or not express their worries [12]. The surroundings and atmosphere in connection with an acute admission might make it feel right for the staff to have the upper hand. It is also possible that it is of interest to the patient in the acute phase as the patient does not have to make any decisions then but can leave everything to the staff. However, there exists no knowledge about it.

We have conducted a pilot study and asked the nurses what they thought were important for the patients. The pilot study took place in 2000 and was solely based on the nurses' conviction. Thus, it does not represent the patients' perception and assessment of the admission. The most important findings of the study [13] are outlined in Box 1.

With the intention of improving the quality of care and treatment among ACS patients, this study firstly focuses on patient perception and assessment of admission, and secondly

compares the results with the above mentioned pilot study which was carried out from the same unit [13,14].

2. Materials and methods

2.1. Design

A qualitative descriptive analysis of semi-structured interviews was chosen to disclose the patient perception and assessment of care and treatment. This method not only brings about valid information, but can also provide a basis for further analyses [15]. The method is characterised by a naturalistic approach without predefined theoretical perspectives or predetermined variables. Although it has similarities to other qualitative methodologies and borrows both approaches and procedures, it remains relatively tangible and true to the data in contrast to phenomenology and grounded theory, which both insist on a higher degree of interpretation. This study has employed some grounded theory procedures as a source of inspiration to our analyses. These included an open and selective coding of transcribed interviews carried out with a comparative analysis approach [16,17].

2.2. Data collection

The study included 30 patients with a diagnosis of ACS, and was carried out from 1st April to 21st October 2000. The patients were consecutively recruited on admission to the cardiac unit with chest pain, providing they fulfilled the criteria of being able to speak and understand the Danish language and participate in a dialogue with the interviewer. Exclusion criteria were: diagnosed senile dementia, misuse or psychiatric illness. The interviews were conducted by three well-instructed nurses at the cardiac care unit (CCU). Patients were asked to participate before they were discharged from hospital and an agreement for appointment was made with the patient. Patients were informed by one of the three nurses, and they could freely choose where the interview should take place, either at the patient's home or at the hospital. Our interview guide was semi-structured with open-ended questions. The questions were divided into three topics; symptom debut, arrival at the hospital and prior knowledge.

The main focus was "arrival at hospital". We asked the following questions: Can you tell me about your admission to hospital? What did the nurse say to you? What did the nurse do? What did the doctor say? What did the doctor do? Could you tell the difference between the hospital staff? How did you experience the contact with the hospital staff when you were admitted?

We used "symptom debut" at the start of the interview and "prior knowledge" at the conclusion. The interviews were carried out within a month from the patient's discharge from hospital and took place in the home of the patient or in an interview room at the hospital, whichever the patient

Box 1 Results from a pilot study among nurses at cardiac care unit

What the nurses think the patients emphasize
Pain preoccupies the patient's consciousness a lot
The patient is in shock when acutely admitted
Monitoring devices are alienating
A lot of people on the admission ward create insecurity
Introduction of responsible nurse means less as long as treatment takes place

preferred. All interviews were audio recorded and transcribed verbatim.

2.3. *Ethical considerations*

The research study was discussed with the local Ethics Committee, leading to the conclusion that further approval with an Ethics Committee was neither relevant nor necessary. The patients in the study were informed both oral and by a written letter, by one of three instructed nurses in the ward. Patients had to sign an informed consent to participate in the study.

2.4. *Results*

Results are based on a qualitative interview examination aiming to show what preoccupied patients with ACS during the first hours of their admission to the cardiac unit.

All 30 patients admitted to the CCU from 1st April to 21st October 2000 consented to participate in the study. The patients included 22 men and 8 women aged 29 to 79 years, with an average age of 59 (SD=11.5) years. In all, 5 themes were identified in the interviews: efficiency, professionalism, pain management, compassionate nursing and information. These themes were considered essential and all together they expressed what mainly preoccupied the patients. Most important was whether the nurses were competent. The patients felt in good hands when they perceived that the nurses were professionally competent.

They took my blood pressure and a cardiogram, and then someone else came and took some blood for tests. I felt in good hands right away. Definitely. The way they treated me? They were first rate!

It was important for the patients to see and feel that the nurses were competent, had technical skills, and were observant and caring. The patients noted and appreciated the nurses' care, but the technical skills and proficiency of the nurses appeared to mean more to the patients during the first hours of their stay at the cardiac unit.

2.5. *Efficiency*

The patients felt that the staff was ready and waiting to assist them during their admission. They experienced a lot of activity and everything happened very quickly. The atmosphere could be hectic, but not necessarily in a negative way:

It was chaos and confusion. There were so many faces. I thought to myself, what a lot of people waiting for me. It was fantastic. They put the drops up really quickly, here and here. I don't know whether I had actually expected that you would be waiting for me. Everything was ready for me in the emergency room. I can't remember very much, but all of a sudden a lot happened very quickly. It was very efficient.

2.6. *Professionalism*

The patients preferred the nurses to be skilful and know exactly what to do and when to do it. They observed the way the staff performed and noted what the nurses said and did when they arrived at hospital even though they were not always aware of what was going on:

I can't quite remember what the nurse who admitted me said nor did, I just can't remember. They strapped me up to all sorts of things, on my legs and arms, on my chest and stomach. I had plasters all over me. When they explained what was going on... I just nodded and that was that. But it wasn't anything I thought about. They did what they did. Very well-planned and skilled work ... I felt that they all knew what to do.

2.7. *Pain management*

The patients were often in a lot of pain on admission to the cardiac care unit. They felt that the staff relieved their pain as quickly as was possible, but felt, however, that the pain management was not always adequate:

They started on me as soon as I arrived. I was very happy with it. I was writhing around a bit. It still hurt up here. They gave me a jab, but it didn't really help. They gave me more jabs and put up a drop and everything. It was as though everything was swimming before my eyes...it started hurting terribly again. So I don't really remember all the details.

2.8. *Compassionate nursing*

The patients registered the internal relations between the staff and between the staff and patients. The patients interpreted the body language and facial expressions of the staff and formed an impression of how busy it was in the unit and whether there was time for the individual:

The nurses were wonderful. It was great and I admire your colleagues very much. I knew very well that it was close to the end of their duty and they were still fantastic. I couldn't put a finger on anything. They were very caring — it was fantastic. They were so pleasant and helpful and concerned about me. It was as though I wasn't just a number. I didn't feel that. It was just great.

The way the nurses cared for the patients in the acute phase was difficult to describe in detail, but it was still noted by the patients. It had a special score, and was rated along with quick reaction, clinical flair, technical nursing skills, and finally collaboration with the doctor:

The nursing has been fantastic all the way through. I don't feel that the patients here are numbers. I think you do a lot for each patient. The nurse and I were on the

same wavelength immediately. There was no waiting time. Everything was great. If something was wrong, they were there for me.

2.9. Information

The patients were informed during the acute phase and their assessments of this information ranged from chaos to detailed and useful information. The patients were not quite sure that they could remember the information they had been given. Tone of voice and choice of wording were very important for the patients. One patient said that he was told to “lie still” which he faithfully obeyed and lay staring at the ceiling. No one told him that he was only to lie still while the Electro Cardio Gram (ECG) was being done. He did not dare move and ended up as stiff as a board.

No, I never found out who was responsible for me. I don’t know whether there were a lot of people. I just lay still and stared at the ceiling. I had been told to lie absolutely still and keep quiet. I tried to. No, I don’t remember.

This quote also underlines how important the delivery of the information is:

It wasn’t a blood clot. They came and said that no heart tissue was affected. Then they said that some tissue may have been involved, that it might have been a spasm and then they said it could have been a main artery. I just didn’t know what was going on. They gave me nitroglycerine and it helped straight away.

In general, the patients were very focused on whether the nurses were professionally competent, that they were efficient, technically skilled and had surplus enough to be sincere, sympathetic, committed and eager to help the patient.

The patients’ and nurses’ perception differed in relation to the significance of having technical devices attached. The nurses thought that the patients would feel the technical devices alienating and fear-provoking [14,18]. But contrary to this perception, the technical devices and many people surrounding them made the patients feel safe. Box 2 describes identical and different perceptions among nurses and patients.

Box 2 Comparison of patient perception and nurse perception

Patient perception	Nurse perception
Patients cannot remember what the nurses tell them when acutely admitted	Patients are in shock when acutely admitted
Pain preoccupies the patients’ consciousness	Pain preoccupies the patients’ consciousness
Monitoring devices create security	Monitoring devices are alienating to the patients
A lot of people on the admission ward create security	A lot of people on the admission ward create insecurity

3. Discussion

3.1. Significance of the findings

The body of knowledge on patients’ perspective on the first hours of admission to cardiac care unit is limited. In the following discussion we include the articles which we found relevant.

The results showed that it was important for patients to be among experts, and it was important that doctors and nurses “knew their job”. If the patients experienced a well-organized admission, technically skilled providers, professional competency and an ability to create a positive interhuman contact, the patients felt well-treated.

There seems to be a correlation between patients’ and nurses’ assessment of the patient being in shock in the acute phase of admission. This is based on the fact that the patients did not remember what the nurses who received them said or did, that the patients found it difficult to distinguish the staff from each other and had difficulties in remembering and understanding the information they got.

Nurses as well as patients mentioned pain as a significant problem. Among some of the patients pain management was ineffective, and likewise the nurses felt they provided inadequate pain management, especially if the patient needed more analgesic than the average patient. Bondestam [10] discusses the complexities of pain management and has revealed a positive correlation of the pain intensity assessed by the patient and the responsible nurse, respectively. The pain intensity was assessed within 24 h. It appeared that a small group of patients in great pain was not treated and when they got the analgesic it was often ineffective. It is questionable why the results, when published in 1987, did not give rise to further examinations of pain management among patients with ACS and may lead to the development of more specific guidelines within pain management of this group of patients. Pain might also be a contributory cause that the patient did not listen to the information. However, our data cannot provide a clear picture of this connection.

The patients noticed competent and qualified staffs which was a combination of technical flair, professional skills and an ability to solve the problems currently arising. Trusting the nurses the patients thus safely left their bodies in their care. It looked as if the nurses were worthy of the patients’ confidence although our findings indicate how the confidence can break due to thoughtlessness. One example is a patient who was asked to lie completely still while the ECG was done. The patient followed the order. But he was not told that he was allowed to move after the ECG was done and thus lay staring at the ceiling for a long time. It was probably an orthodoxy patient and could be an example of experienced “non-care” nursing and solely technical skilled nursing. One explanation might be that the patient, corresponding to the study of Nyström et al. [12], felt embarrassed and did not feel like telling his problems or ask questions. Maybe because the health care providers tended to focus on technical skills

instead of providing general care which also includes psychological aspects.

Phenomenological patient descriptions of vulnerability [19,20] show that the patients are aware of their sensitivity towards the response from the care providers. This perception might feel less problematic if patients feel they are involved in own care and treatment [21,22]. In the acute phase patients do not necessarily wish to take part in the decision process, on the contrary they leave their body to the hospital staff [20,23]. There is reason to believe that the patients, while in the acute phase, merely need direction of actions than being involved in decisions and that the patients may have different attitudes as to how much they want to participate in own care, also over time. During all phases of admission it is thus important to find the right balance between the desired and actual participation in care and treatment of the individual patient [9].

The most important result was that ACS patients, despite pain, were able to assess whether the care providers were skilled, meaning that the providers possessed technical flair, sympathy, care and the ability to ask about the patient's wishes.

3.2. Limitations of the study

This study deals with the care and treatment of patients in the acute phase of hospital admission where there is no clear division between the duties of nurses and doctors.

The hospital staffs work in teams to ensure the best possible acute care and treatment. This is mirrored in the patients' perception and assessment, which do not necessarily relate exclusively to nurses, but are rather a general impression of the health professionals' teamwork.

All of the invited patients consented to take part. Lapses of memory can occur as the interviews were carried out within a month of the patients' discharge from hospital. The patients did their utmost to recall all the details of their admission. The fact that the interviewer was a nurse may have led to the patients feeling obliged to gratify the interviewer. A hospital stay with a positive outcome may result in the admission experience being remembered more favourably than it was at the time. On the other hand, an admission performed by a stressed hospital personnel may be remembered less positively than it actually was.

Our findings show that it is possible to disclose key areas of patient perception and assessment of the treatment — also in acute cardiac sessions. The study cannot, however, reveal how the individual patient prioritises the key areas. This would require a quantitative study design with purpose-made questionnaires to facilitate further quality development of the treatment and care of acute cardiac patients.

4. Conclusion

The results document the patients' own assessments of the acute phase of hospital admission. The patients notice and stress the importance of whether the nurses show care and know their

job. In general this is the case, and confident of the nurses' competency the patients leave their body in the nurses' care.

There is a predominant correlation between the patients' experiences and assessments on one side, and the nurses' recognition of these experiences and assessments on the other side. But one point differs; the patients find the technical device and many people on the ward secure, whereas the nurses think the patients find the technical devices alienating and the many people around them insecure. Some patients find pain management inadequate. This corresponds to the nurses' perception. This requires further investigation. The fact that the patients, in confidence, leave their body in the nurses' care raises the question to which extent the nurses have informed the patients in detail about instrumental actions. Furthermore, it gives rise to direct attention to the fact that patients in the acute phase may be very orthodox and thus need specific directions of action.

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