



Patient and caregiver experience following ambulatory surgery: qualitative analysis in a cohort of patients 65 yr and older

Expérience des patients et aidants naturels après chirurgie ambulatoire: analyse qualitative d'une cohorte de patients âgés de 65 ans et plus

Gregory L. Bryson, MD · Chris Mercer, MD ·
Lara Varpio, PhD

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Abstract

Purpose Patients over the age of 65 represent 15% of Canada's population and one-third of patients undergoing surgery. Older surgical patients often have lasting disability following "minor" ambulatory procedures. This study sought to explore the postoperative experience of ambulatory surgery, as described by older surgical patients and their caregivers.

Methods Following research ethics board approval, patients 65 yr of age and older who were booked for ambulatory surgical procedures and their caregivers were recruited for the study. Both patients and caregivers were

given a daily diary in which to respond to questions assessing functional autonomy, postoperative pain, and caregiver burden. Each daily entry concluded with the following request: "Using the space provided, please record any comments related to your postoperative experience as a patient (caregiver) that you feel are important for us to know." Responses were analyzed for emergent themes using qualitative description.

Results There were 105 patient-caregiver dyads assessed: 90 patients and 64 caregivers offered at least one response. Ten themes, each with a positive and negative construct, clustered around three categories emerged from the comments. Anticipated themes regarding efficacy and side effects of perioperative care were noted. The impact of physical disability on home life was vividly described. Both patients and caregivers expressed concerns regarding preoperative information and postoperative support from the institution.

Conclusions Patients and caregivers ardently described real challenges during convalescence. Ambulatory care facilities should prepare this specific demographic of patients and caregivers for the post-discharge experience. Paramount for participants was the need for clear communication and a commitment to ongoing support following discharge.

The trial on which this analysis was based was registered with ClinicalTrials.gov (NCT01382251).

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Author contributions All authors contributed to the concept and design of the paper, reviewed the analyses, and participated in the preparation of the submitted manuscript. Gregory L. Bryson secured funding for the original study. Gregory L. Bryson, Chris Mercer, and Lara Varpio developed the coding structure and developed the NVIVO data set. Chris Mercer coded the data while Lara Varpio supervised the analysis. Gregory L. Bryson had full access to the study data and takes responsibility for the integrity of the data and the accuracy of the data analysis.

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G. L. Bryson, MD (✉) · C. Mercer, MD
Department of Anesthesiology, The Ottawa Hospital, 1053
Carling Avenue, Box 249C, Ottawa, ON K1Y 4E9, Canada
e-mail: glbryson@ottawahospital.on.ca

L. Varpio, PhD
Department of Medicine, Uniformed Services University of the
Health Sciences, Bethesda, MD, USA

Résumé

Objectif Les patients âgés de plus de 65 ans représentent 15 % de la population canadienne et un tiers des patients subissant une chirurgie. Les patients chirurgicaux plus âgés ont souvent un handicap durable après des

procédures ambulatoires « mineures ». Cette étude a cherché à explorer l'expérience postopératoire de la chirurgie ambulatoire, telle que décrite par les patients chirurgicaux âgés et leurs aidants.

Méthodes À la suite de l'approbation du comité d'éthique de la recherche, des patients âgés de 65 ans et plus qui devaient subir une procédure chirurgicale ambulatoire programmée et leurs aidants ont été recrutés pour l'étude. Les patients et les aidants ont reçu un carnet journalier dans lequel ils devaient répondre à des questions évaluant l'autonomie fonctionnelle, la douleur postopératoire et la charge de travail pour l'aidant. Chaque entrée quotidienne se terminait par la demande suivante: « Veuillez indiquer dans l'espace prévu tous vos commentaires concernant votre expérience postopératoire en tant que patient (aidant) qu'il vous semble important de nous communiquer. » Les réponses ont été analysées à la recherche de thèmes émergents en utilisant une description qualitative.

Résultats Cent cinq dyades patient-aidant naturel ont été évaluées: 90 patients et 64 aidants ont fourni au moins une réponse. Dix thèmes comportant chacun un élément positif et un élément négatif, regroupés dans trois catégories, sont sortis des commentaires. Les thèmes attendus concernant l'efficacité et les effets indésirables des soins périopératoires ont été notés. L'impact du handicap physique sur la vie au domicile a été décrit de façon vivante. Les patients et les aidants naturels ont, tous deux, exprimé leurs préoccupations concernant l'information préopératoire et le soutien postopératoire reçus de l'établissement.

Conclusions Les patients et les aidants naturels ont ardemment décrit les vrais défis rencontrés au cours de la convalescence. Les établissements de soins ambulatoires devraient préparer ce groupe particulier de patients et d'aidants naturels à l'expérience suivant le congé de l'hôpital. D'une importance primordiale pour les participants était le besoin d'une communication claire et d'un engagement pour un soutien continu après la sortie de l'établissement.

L'étude sur laquelle s'est basée cette analyse a été enregistrée sur le site ClinicalTrials.gov (NCT01382251).

The 2006 National Survey of Ambulatory Surgery documented that one-third of all ambulatory surgeries were performed on patients over the age of 65.¹ Research on the functional sequelae of ambulatory surgery has focused on younger patients;^{2,3} the impact of these surgeries on older surgical patients and those who care for them following discharge is poorly understood. Our group recently reported the outcomes of a cohort of older

ambulatory surgery patients and their family members.⁴ Assessment of both basic and instrumental activities of daily living indicated that recovery of preoperative function is delayed for a minimum of a week. Caregiver burden reported by partners and children was highly variable, but the degree of disability experienced by both patient and caregiver was associated with the increased burden of care.

Our contact with the older patients and their caregivers enrolled in this study suggested that, while return visits to hospital were rare, many patients and their families struggled with care-related issues following surgery. Study personnel frequently resolved patient and caregiver concerns during their follow-up calls. In our previous study, comments recorded by both patients and caregivers in their daily diaries suggested challenges that were not apparent in the standard quantitative measurement tools used in the study. The association between quantitative measurement tools and narrative experience may be inconsistent when assessed in physical and mental health care settings. In a study using several well-validated assessments of function in a cohort of 108 patients undergoing knee arthroplasty, objective measures of knee function were poorly correlated with patient satisfaction, as assessed by a simple visual analogue score.⁵ A longitudinal cohort study of 183 psychiatric patients found that subjective measures of quality of life (affect balance, self-esteem, service satisfaction) were at odds with objective measures (hours of work, contact with family, independent living) both at initial assessment and over time.⁶ In a patient-centred model of care, the patient's subjective experience should be clearly heard. We therefore undertook a qualitative evaluation of patient and caregiver experiences to acquire a better understanding of their post-discharge care events.

The primary objective of this study was to illuminate themes relevant to post-discharge care among a cohort of ambulatory surgery patients 65 yr of age or older and their primary caregivers, as described in their written diaries.

Methods

This study analyzed narrative comments recorded in daily diaries collected from patients aged 65 yr and older and their primary caregivers who were enrolled in an observational cohort study of outcomes following ambulatory surgery. For the purpose of this study, the primary caregiver was defined as either the patient's partner or an adult descendant. This study was approved by the Ottawa Hospital Research Ethics Board (Protocol Number 2009390, approved October 29, 2009). The primary clinical outcomes have been reported elsewhere.⁴

All surgeries were performed at The Ottawa Hospital, a 900-bed tertiary care university-affiliated hospital that includes a free-standing ambulatory surgical centre. Several days to weeks prior to surgery, all participants received an on-site preoperative screening and teaching evaluation by nurses working in the preoperative assessment clinic. Preoperative clinic nurses identified potential research subjects for the research personnel. Screening began on July 1, 2010, and the final assessment was completed on January 4, 2012.

Patients scheduled for elective ambulatory surgery (hip, knee, and shoulder arthroscopy, foot surgery, lumbar discectomy, inguinal or ventral herniorrhaphy, laparoscopic biliary or gynecological surgery, and genitourinary repair surgeries) with an anticipated length of hospital stay of 23 hr or less were assessed for eligibility. Eligible patients were 65 yr of age or older with an identified partner or adult descendant as their primary caregiver. Patients were excluded if they resided in a nursing home or received professional support services; similarly, caregivers hired to assist the patient were excluded. Patients and caregivers were excluded if they were unable to read and write in English or French. Participation was restricted to those dyads in which both the patient and caregiver provided written informed consent.

Following surgery, patients were given standard written hospital discharge booklets that included care instructions and indicated surgeon and day surgery unit contact information. Postoperative follow-up calls are not routine at The Ottawa Hospital. Both patients and caregivers were given a daily diary in which they were instructed to respond to questions assessing functional autonomy, postoperative pain, and caregiver burden on postoperative days one to five (Appendix 1; available as Electronic Supplemental Material). Each daily entry concluded with the request: "Using the space provided, please record any comments related to your postoperative experience as a patient (caregiver) that you feel are important for us to know." Diary entries were copied from handwritten notes to electronic text documents by a research assistant. Entries were copied verbatim and rendered anonymous to facilitate analysis.

Any comment made in the diary was eligible for analysis. A sentence was the smallest unit of text eligible for coding. The data were analyzed using a qualitative description,⁷ an approach that supports descriptive inductive thematic clustering of participant comments. This approach was augmented by employing iterative cycles of open, axial, and selective coding as developed in Grounded Theory.⁸ All three investigators participated in all phases of the coding to create, test, and vet

emergent themes in relation to participants' postoperative experiences.

During open coding, the investigators independently read through the data to identify emergent themes. Regular team meetings were held to compare and discuss the independently generated themes until consensus was reached on the emergent themes. When a unit was coded to a theme, it was also coded as having been stated by the patient or caregiver and as being a "positive" or "negative" example of the theme. Positive comments expressed good outcomes, unexpectedly mild or improvement in symptoms, and satisfaction with care received. Negative comments expressed poor outcomes, adverse effects of treatment, and disappointment with care. In this way, for example, a patient's diary entry stating "I am in real pain today" would be coded as "patient", "pain", and "negative". Individual sentences could be coded with more than one theme if applicable.

The axial coding cycles had the investigators identifying categorical relationships between themes. During selective coding cycles, thematic categories were further refined. Themes were subsequently clustered into related categories. During axial and selective coding cycles, regular team meetings were held to resolve discrepancies, review deviant cases, and build a common understanding of the data.

A sample size estimate based on confidence intervals was performed for the functional and burden-of-care measures assessed in our original report. The current study reports all comments in the daily diaries returned by patients and caregivers and, as such, represents a census of this study population. Descriptive statistics (mean and standard deviation for continuous variables and frequency and percentage for categorical variables) were calculated to summarize baseline demographic data on patients and caregivers. This report complies with the STrengthening the Reporting of OBservational Studies in Epidemiology (STROBE) guidelines.⁹

Results

Participants

Participant recruitment, enrolment, and progress throughout the study are illustrated in the Figure. Demographic characteristics of the 102 patient-caregiver dyads completing the full study are documented in Table 1. Surgeries were evenly distributed among orthopedic (arthroscopy, forefoot, lumbar discectomy) and peritoneal (laparoscopy, gynecology, urology) surgery subgroups. Diary entries from three patient-caregiver dyads who piloted our study instruments were added. Demographic data were unavailable for these pilot dyads.

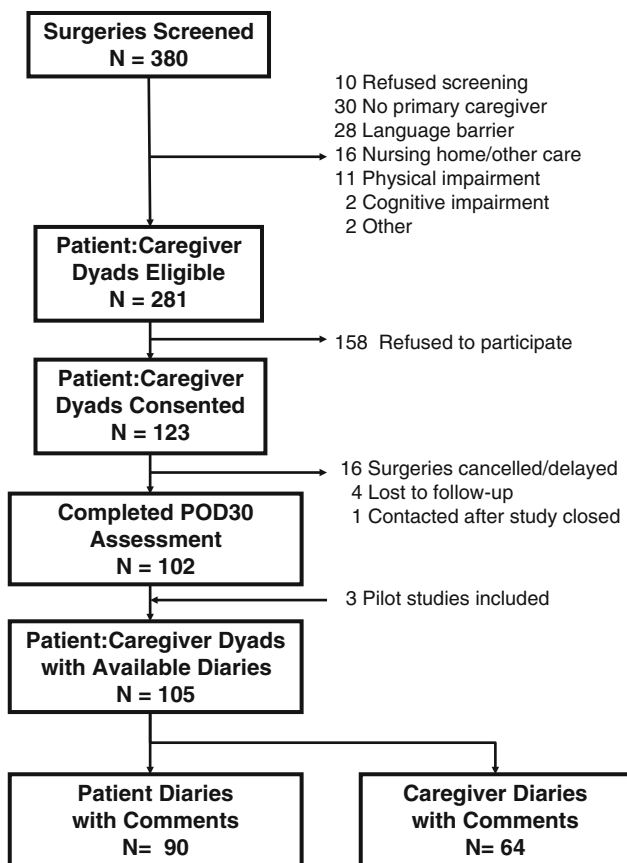


Figure Participant accrual and retention

Table 1 Participant characteristics and outcomes

	Patients (n = 102)	Caregivers (n = 102)
Mean age (SD)	71 (6.0)	67 (11)
Male sex (%)	48 (47)	47 (47)
ASA Physical Status (I, II, III, IV)	(3, 56, 39, 4)	-
Any employment (%)	14 (14)	25 (25)
Caregiver is partner (%)		86 (86%)
Mean SMAF at Baseline (SD)	4.0 (5.9)	2.0 (2.9)
Mean ZBI at Baseline (SD)		9.3 (9.9)

Characteristics of three patient:caregiver dyads who piloted study diaries were unavailable

ASA = American Society of Anesthesiologists; SD = Standard deviation; SMAF = Système de Mesure de l'Autonomie Fonctionnelle; ZBI = Zarit Burden Interview

There were 105 patient-caregiver dyads participating in the study, with 90 patients and 64 caregivers offering at least one comment in their daily diaries.

Data coding

There were 355 patient and 228 caregiver diary entries coded, with several comments receiving more than one code.

Categories and themes

In the following description of results, we provide excerpts from the participants' narrative comments. We selected excerpts that were both representative of the theme and clearly and succinctly expressed. Ten unique themes in three categories were identified and are summarized in Table 2. Definitions of each theme with positive and negative exemplars are documented in Appendix 2 (available as Electronic Supplemental Material).

Category 1 - Physical and emotional health

Pain

Pain management was the most frequently cited aspect of recovery among patients. Comments regarding inadequate pain relief or unpleasant side effects of analgesics were common among patients and caregivers alike:

"I have experienced more discomfort/pain from this procedure than expected. Perhaps the pain medication was not strong enough for the situation." *Patient103*
 "[U]sed Percocet only on first night – would not use again, ever. Didn't feel in control of my actions." *Patient307*

"He is in a great deal of pain and I am having a hard time dealing with this." *Caregiver140*

While these negative perceptions were consistent across the data set, they were somewhat offset by comments reflecting satisfaction with pain management. This may be due, in part, to an aggressive use of multimodal, local infiltration, and regional analgesia techniques in our ambulatory surgery program:

"The popliteal catheter block is a wonderful injection to have done. I had no pain." *PilotPatient2*

Gastrointestinal

Nausea, gas pains, and constipation following surgery made gastrointestinal comments one of the most consistently negative themes identified. A tension between nausea and analgesia, familiar to perioperative clinicians, is highlighted by this patient.

"The pain medication prescribed caused too much nausea. I stopped it and took Tylenol 500 which may have given less relief but which did not cause nausea and vomiting." *Patient126.*

Inability to move one's bowels following surgery was a uniquely distressing and durable problem that led one patient to state:

Table 2 Themes expressed following ambulatory surgery

Category	Theme	Patient		Caregiver	
		Positive	Negative	Positive	Negative
Physical and Emotional Health	Pain	52	103	27	34
	Gastrointestinal	9	33	4	20
	Sleep	12	10	7	4
	Autonomy	34	36	48	24
	Emotional State	14	20	15	17
Hospital Experience	Wound Care	7	17	7	6
	Perception of Being Informed	0	20	1	20
Caregiving	Institutional Support	17	15	7	15
	Caregiver Experience	0	0	21	41
	Caregiver Concern	0	3	0	9

“Constipation and bowel movements are more of a concern than the operation.” *Patient523*

After three days without a bowel movement, this patient called a provincial health hotline at 4:30 AM and presented to the emergency department several hours later when her concerns could not be resolved from home.

Sleep

Negative comments regarding sleep were frequently associated with inadequate pain control and an inability to position one’s self comfortably. One patient vividly described difficulty sleeping associated with pain relievers, stating:

“I decided to take one tablet of Tramadol instead of 1/2, so that it would last all night. I did not like it. I kept waking up with itchy skin and very unpleasant SWISHING sound in my head/brain, especially when I blinked my eyelids - WOOSH-SWISH.” *Patient533*

Wound care

Leaking incisions and dressing changes are second nature to health care providers involved in perioperative care. The same cannot be said for the lay public who voice the need for more guidance in this area. As the following participant comment illustrates, at-home wound care caused significant stress to the caregivers:

“Last night blood was leaking from under tape and a lot of blood was visible through the tape. I called friends and the hospital. The doctor to whom I spoke explained that a lot was normal but that I could go to emergency.” *Caregiver507*

Autonomy

Patients and caregivers alike expressed concern regarding loss of function and independence following outpatient surgery. Patients expressed frustration with their lack of mobility at home:

“1st day at home – scary! Very limited movement. Walking is a problem, carrying anything impossible!” *Patient530*

Caregivers described the effort and commitment required to accommodate the patients’ needs:

“Patient could not get off from sitting position by himself. Caregiver had a hard time helping him out of the chair (heavy) for necessities, washroom, eating, sleeping.” *Caregiver517*

Emotional state

Patients and caregivers were forthright in their emotional descriptions of the strain placed on interpersonal relationships during their patient’s convalescence:

“My husband usually helps me with the house chores. Since his surgery, I’ve tried to do most of the chores which makes him frustrated and angry. This helplessness creates a lot of tension.” *Caregiver316*

Maintaining personal and professional relationships beyond the primary patient-caregiver dyad were also reported as sources of stress.

“[Patient’s] mother is asking for more care, my boss is asking for extra hours, [patient] still needs more care than previously – I’m a basket case.” *Caregiver130*

Category 2 - Hospital experience

Perception of being informed

In terms of the hospital-related comments from study participants, the most ardently expressed negative comments made by both patients and caregivers regarded a sense of being unprepared for the perioperative experience. The vast majority of patients underwent an onsite preoperative assessment visit several days before surgery and received a phone reminder the night before the operation. Despite these personal contacts, it was apparent that the model of care was not clearly understood. For example, this patient remained unclear regarding the route of admission:

“Confusion as to whether I was going home the same day. My family was told I was staying. It would be better to tell them that it has not been decided yet. I was released the same day.” *Patient303*

Oral instructions provided by our nursing team were reinforced with written information booklets for the day surgery unit and for the procedure itself. Regrettably, study participants clearly considered the written discharge instructions to be unclear or contradictory:

“Sheets of instructions given at discharge are contradictory even though both have the doctor’s name on them.” *Patient133*

Both patients and caregivers were unsuspecting of the degree and duration of disability following an outpatient procedure:

“My expectations were I would be mobile and able to care for myself and make my own meals. The reality was I was confined to bedroom and nearby bathroom.” *Patient526*

“I was under the impression that keyhole surgery would result in an easy recovery. The patient is age 66. Her recovery is more difficult and lengthy than I had anticipated, e.g. over soreness and mobility.” *Caregiver135*

Institutional support

Comments regarding the care provided by the hospital were mixed; a division between in-hospital care and post-discharge support was evident. Most patients expressed satisfaction with the care they received in hospital and the health care professionals providing it:

“All the staff at the hospital were professional, courteous, sympathetic, and competent. Thanks to all of them!” *Patient524*

On the other hand, many families felt adrift once discharged. Patients were instructed to contact their physicians with concerns following discharge. The following caregiver and patient comments highlight that finding someone with whom to address those concerns was a considerable source of frustration:

“I feel frustrated and disappointed in the medical services. Trying to get through the office for an appointment and through automated message machine, found out they’re on holidays until August 2. Now who do I call or where do I go???” *Caregiver316*

“I was told to remove my bandage today and when I did there were a number of smaller bandages criss-crossing the incision. Don’t know if I am to remove these - and Dr. office closed for weekend. My instructions were not clear.” *Patient537*

Patients and caregivers alike clearly identified the need for the hospital to improve communication strategies for outpatient care. This caregiver comment is one of several suggesting that a “hotline” be established to deal with post-discharge follow-up:

“It would be helpful if a telephone # was given to caregiver by which he could ask simple questions that arise during care period. Contacting MD involved very difficult and often info required is for reassurance.” *Caregiver103*

Category 3 - Caregiving

Caregiver experience

The experiences reported by caregivers were highly variable. Most caregivers balanced statements of their own frustrations and negative feelings with words of support and thanks for their patient. For example:

“Caring for my wife is not too bad but the other things like cooking, cleaning, shopping for groceries is starting to wear me down.” *Caregiver532*

Similarly, this caregiver is pleased that her patient is doing well, but regrets the time taken from other family relationships:

“Trying hard today to catch up on work and family contacts that I have let slip. Stressful but patient is doing well so that’s good.” *Caregiver142*

Despite the challenges inherent in caregiving, it was clear that many families enjoyed their role as caregiver and valued the opportunity to assist a loved one:

“The crises of the week are now behind us. Problems have been mutually resolved to good end. This situation was dealt with as we deal with all such matters - logically and together. The patient is well on her way to recovery. We are still married and no one is any the worse for wear.” *Caregiver551*

Caregiver concerns

Albeit relatively infrequent, we were surprised by comments from caregivers that expressed a desire to hold their patient back. While health care providers expect and encourage mobility following surgery, it was clear that this expectation was not shared by all caregivers:

“I’m having some problems in keeping him from doing too much exertion; but mostly, in the end he’ll listen.” *Caregiver101*

While well motivated, these concerns appeared to be a source of conflict within the patient:caregiver dyad:

“I look into the kitchen. There are 3 days worth of dirty dishes. Corn husks and dead strawberries look at me blearily from a colander. Surely I can wash dishes, I say. They aren’t heavy. No he says. Go lie down. When he is not looking I turn off the lights and close the kitchen cupboard doors.” *PilotPatient1*

Discussion

Older patients and their caregivers reported ten themes in three categories that defined their post-discharge experience following ambulatory surgery. Issues regarding physical and emotional health, including inadequate analgesia, medication side effects, and emotional stress, were most frequently reported. Health care workers who are experienced in ambulatory care would anticipate such concerns. The vivid descriptions of impaired mobility and frustrations with wound care were somewhat surprising and suggest that more information on these issues be included in perioperative teaching materials. The most consistently negative feedback occurred when the hospital experience was considered. Patients and caregivers voiced many concerns regarding quality and content of their discharge instructions and their inability to access help once discharged. Caregiving was a source of both stress and satisfaction for the families of our patients. Comments in this category provided a unique and privileged window into the lives of our patients and their families.

Decreases in physical health and mobility were reflected in changes in the primary quantitative measure of our original study.⁴ These findings were consistent with previous

research in younger ambulatory surgical populations.^{2,3} It should be emphasized that the objective of our research program was to describe the experience of older surgical patients. We cannot, therefore, directly compare or contrast our findings with younger patients. Our findings do, however, indicate a significant decrease in autonomy that warrants prospective evaluation in a broader spectrum of ambulatory surgery patients. Both objective and subjective assessments of patient function indicated that our older patients required assistance for up to a week following ambulatory surgery. We suggest that preoperative education materials highlight both the severity and duration of functional impairment after surgery and encourage an objective assessment of patient function as a core outcome measure in ambulatory anesthesia.

Pain and postoperative nausea and vomiting have long been recognized as primary concerns among ambulatory surgery patients;¹⁰ comments from both patients and caregivers indicate that this remains the case. The frequent comments regarding inadequate analgesia and those complaining of constipation indicate that opioid analgesics were poorly tolerated in our older surgical patients. Patient comments suggest that non-opioid analgesics, locoregional analgesia, and strategies to maintain regular bowel habits would be welcome.

We had anticipated that the burdens of care might weigh heavily on our patients’ families but found little change in the Zarit Burden Interview scores that objectively assessed this outcome.⁴ Diary comments suggest that the stresses and inconveniences of caregiving might be mitigated by the sense of purpose and enjoyment of caring for another. The benefit of caregiving, referred to as caregiver reward, has been documented in a number of conditions, including cancer,¹¹ mental illness,¹² and dementia.¹³ It would appear that a nuanced assessment of care that includes both burdens and rewards is required to document the experience of adult family members providing support for the ambulatory surgical patient.

Our findings regarding patient and caregiver dissatisfaction with information and institutional support must be recognized. A number of well-validated measures of patient satisfaction with ambulatory anesthesia are available,¹⁴ and most place a high value on clear information and communication with health care workers. Eighty-five of 105 possible points in the Leiden Perioperative Care Patient Satisfaction Questionnaire assess information and staff-patient relationships.¹⁵ Similarly, a survey of over 900 patients and 350 health care workers showed that patients were more likely to value non-technical aspects of care, information, and psychosocial support than their clinicians.¹⁶ Our results indicated that patients and caregivers considered themselves unprepared for themes such as wound care, autonomy, and emotional state. Written teaching materials from The Ottawa Hospital touch on many

of these issues, but it is apparent that either the content or format of this information did not suit the needs of many of our families. Negative patient and caregiver perceptions of being informed remind us that only 25% of information given to patients and caregivers in the care setting is correctly heard, interpreted and recalled.¹⁷ Some may consider communication and care following discharge to be the responsibility of the surgeon or the care facility; however, these concerns are congruent with the broader construct of team-based care and the anesthesiologist as “perioperative physician”.¹⁸ Anesthesiologists have taken a leadership role in expanding the scope of ambulatory surgery. We offer increasingly complex outpatient analgesia¹⁹ to increasingly complex patients;²⁰ our attention to communication and support structures must keep pace with these technical skills. Ambulatory surgery facilities might consider inclusion of patient and family representatives in the development and ongoing assessment of outpatient surgical education programs.

Regardless of the quality or quantity of perioperative education, comments regarding institutional support following discharge indicate that a number of needs have not been met. Both patients and caregivers expressed frustration in accessing health care providers for problems arising at home. Institutions may be in a better position to address concerns than individual surgeons who may be difficult to contact outside business hours. Ambulatory surgical centres might consider the request made by a number of our patients and caregivers to establish an on-call contact service, by phone or electronic messaging, to address post-discharge needs and provide reassurance.

Our study is limited by its design. Our initial cohort study was not designed specifically to elicit narrative comments for formal qualitative analysis. Daily diaries included elements of our quantitative outcome measures and an instruction to report concerns “that you feel are important for us to know”. These items may have framed or directed the comments we received. We cannot, therefore, be confident that the comments relating to pain, autonomy, and caregiver burden accurately reflect the prevalence of these issues in the population. Our results are also subject to reporting bias. Only the views of those participants voluntarily providing written feedback were considered. A study involving multiple modes of feedback (survey, open narrative, focus groups) might have provided a broader range of respondents and experience. We are, however, confident that our patients and their caregivers provided an honest reflection of their experience – an experience perhaps underappreciated by their health care providers. Our results are specific to a single academic health science centre. Participants from other institutions with more advanced perioperative models of care or more effective discharge information systems may report fewer

or different concerns. That said, the importance our patients placed on information and communication are consistent with the ambulatory care literature.

In conclusion, we found that patient and caregiver narratives highlighted concerns regarding physical and emotional health, institutional support, and the caregiving experience following ambulatory surgery. As Patient 558 clearly described, “This home after-surgery is not for too many seniors and/or sissies.” It is likely that health care workers underestimate the impact of outpatient surgery on the mobility of older surgical patients and fail to communicate this to their patients. Preoperative teaching and post-discharge information should be structured to address the three categories of postoperative experience described. These categories may inform interventions to help seniors transition from hospital to home-based care and provide means for helping these populations manage the transition and the tensions inherent therein. Attention to communication following discharge is likely to be an important predictor of patient satisfaction. Providers would be wise to address these needs as health systems in both the United States^A and United Kingdom^B explore means to incorporate patient satisfaction in evaluation and funding schemes.

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Conflicts of interest None declared.

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